TRAINING IN CLINICAL PSYCHOLOGY

Transactions of the
First Conference
March 27-28, 1947
New York, N. Y.

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First Conference on Training in Clinical Psy
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Chairman: DR. LAWRENCE S. KUBIE

Editor: DR. MOLLY R. HARROWER

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THE ROLE OF THE CONFERENCE IN SCIENTIFIC INVESTIGATION

FRANK FREMONT-SMITH
Josiah Macy, Jr. Foundation

ON BEHALF of the Josiah Macy, Jr. Foundation I would like to start off with a few words in regard to the Foundation's conference program before I turn the meeting over to the Chairman, Dr. Lawrence S. Kubie.

This Foundation was formed in 1930. The donor, Mrs. Kate Macy Ladd, believed that a foundation's function should be more than making grants in support of research; that a foundation was in a position to do something more constructive than merely making funds available. Her thoughts were greatly inspired by Dr. Ludwig Kast, the first President of the Foundation. In her original Letter of Gift, she said that she hoped the Directors would be more interested in the "architecture of ideas than in the architecture of buildings." We are here to build some ideas. The Directors have been aware that with the departmentalization of science, which is probably inevitable, there will always be times when cross-fertilization across departmental barriers will be necessary; that in the solution of many basic problems a multi-discipline approach will be most fruitful.

We have for some time been interested in the conference method for furthering scientific investigations. The experiment you are participating in today is an example of the current stage in our development of the conference idea. We started off with large, rather formal conferences, but came to realize that informal round-table discussions were much more effective. In the ordinary scientific meeting the percentage of time allotted to discussion is very small. The emphasis is upon formal presentations. Our thought has been to encourage informal presentations—emphasizing problems, concepts and unsolved issues—presentations which would be provocative of discussion and informal exchange of ideas. We have felt that much would be gained if an investigator were willing to expose his ideas, before they were committed to publication, to the critique of others who are interested in the same problem but who approach it from somewhat different points of view. Our conferences have brought together men from different disciplines interested in a common problem for free and informal discussion and in order that they might get to know one another. In this conference many of you are already acquainted, but I hope that each one will find someone here whom he will know better at the end of the two days. One of the major stumbling blocks in science in the past has been the difficulty of communication. We feel friendly acquaintance provides the best atmosphere for communication. We are asking you, therefore, to participate in this experiment in communication.

I am happy to welcome today the guests and members of this conference.

CONFERENCE ON TRAINING IN CLINICAL PSYCHOLOGY

Morning Session

March 27, 1947

THE EVOLUTION OF A CLINICAL PSYCHOLOGIST

MOLLY R. HARROWER
Psychological Consultant, Department of State

THE title, "The Evolution of a Clinical Psychologist" has, I am afraid, all the earmarks of the type of autobiographical ramble indulged in by the after-dinner speaker. This, however, is not my intention. The few pertinent personal details can be dismissed in a paragraph. The choice of the words "a psycholo*gist*" rather than "psycholo*gists*" or "psychology" is to point up my belief that we have, at the present time, *no discipline of Clinical Psychology* in the same sense that we have Medicine, Law, Dentistry, or Teaching. And that there *are,* in consequence, *no uniformly trained Clinical Psychologists* in the sense that there are doctors, lawyers, dentists, or educators. To date, we are entitled to use the words "*clinical* psychology" only to differentiate an area of interest or activity other than the academic, to which the academically trained psychologist has devoted himself; that is, an interest in particular persons—in patients, maladjusted children, delinquents, and adolescents. And we have in the field a relatively small group of individuals, grounded in theory and experimental techniques, who have exposed themselves to dynamic psychiatry, immersed themselves in some medical atmosphere, and faced the question of therapy through personal analysis, but who have achieved these indispensables by diverse methods and often with great difficulties. Such persons, largely by virtue of their own haphazard training and the obstacles which they have had to overcome, have emerged with a pretty clear conception of what professional training in the field should ultimately include.

As a reference point, let me state here that my own background included four years of "pure" research in visual perception, memory, and thinking, and two years of college teaching, prior to a thoroughly academic doctorate. Thereafter, in an effort to reach my goal, which I may define as the relevant evaluation of personality in order to throw light on psychic and somatic disturbances, I tried three years of guidance and personnel work, four years of total immersion in the organic atmosphere at the Montreal Neurological Institute, three years as research psychologist in a Department of Neuropsychiatry, and two years free-lance teamwork with my medical colleagues here

in New York. Thus it is from the standpoint of these twelve years of post-Doctoral groping that I speak now of the development in my own mind of the concept "clinical" as pertinently attached to that of "psychologist." I am concerned with the thought:

When does a psychologist evolve into a clinician?

This is a question which cannot be answered in the classroom, nor can the evolutional phenomenon occur therein. It is born out of the actual struggle to find a place in an essentially alien discipline. It is a state of mind, or, like the Kingdom of Heaven, it is within us. Let me postulate, therefore, some of the most important attitudes and attributes which entitle the psychologist to put a "C" on his psychological sweater.

I. A psychologist may be considered clinical when he is able to take a responsible and unemotional stand on the all-important question of *therapy;* a stand which takes into account that by no stretch of the imagination can it be argued, or by wishful thinking asserted, that there is anything in the regular Ph. D. in academic psychology per se which remotely equips him to do therapeutic work; a stand, however, which does not evade the pressing social issue by blind obedience to the letter of the existing law; a stand by which he shows his willingness to put his own house in order through as rigorous and exacting analytic means as are available to him; a stand which assumes the responsibility to awaken in all his students or younger colleagues the inner need for availing themselves of the maximum degree of self-knowledge before attempting to handle the lives of others; a stand which embodies his belief in the validity of his evaluation techniques, so that he is willing to put them to the test for their intrinsic, therapuetic worth, assuming the responsibility of developing, if necessary, a new therapeutic approach, a new method of handling appropriately selected personality disturbances.

II. The psychologist is entitled to the epithet "clinical" when he ceases to consider himself as the infallible psychodiagnostician—God's gift to the psychiatrist! Or, on the other hand, when he is past the stage of thinking of himself as "successful" only in terms of the number of times when his diagnoses equate with those of the psychiatrist, being elated when his batting average rises, plunged into the depths of despair as his "diagnoses" differ.

Unpopular though this suggestion may be, I personally would like to see even the word "psychodiagnostician" dispensed with, in that it is somewhat pretentious and inaccurate! Actually, psychiatrists do not need the services of psychologists, clinical or otherwise, to make a diagnosis, except in a very few cases. While it may be spectacular, for instance, to call attention to the presence of organic cerebral pathology when none has been suspected, and to have it verified by X-ray, while it may be satisfying to validate "objectively" the psychiatrist's opinion of an underlying schizophrenic process in the demonstrable deviations which appear in the pliable materials of the projective techniques, such cases, though gratifying, form a very small percentage of those a psychiatrist sees or refers.

I would prefer, therefore, for the Clinical Psychologist to emerge in a more positive role, in that of what I might call the assessor, surveyor, or map maker of the dimensions and depths of personality, or to see him envisaged as an explorer of the individual's potentialities and resources. Thus his task would not lie in the diagnosis of a neurosis, but rather in a description of the type of personality in which the neurotic symptoms were finding expression. For when all is said and done, diagnosis is a small part of the battle for all concerned. The psychological clinician must realize that his information is valid in its own right, and that it needs to be presented in such a manner that the therapist can best make use of it in planning for the patient's welfare. He must remember that his long suit lies in being able to answer the question, "What personality resources does this patient possess?" developing, if necessary, new categories, new patterns of personality, new clinical entities, if his material so demonstrates.

Because of our inevitable lack of orientation in the medical and psychiatric fields, we as psychologists are only just reaching the point where we can refrain from the attempt to fit our findings into the pre-existing pigeonholes; where we are realizing that our task lies in presenting our material in a way that does least damage to it.

In the same way, the psychological clinician, in his role of explorer or surveyor, must have reached a point of belief in his own materials and his own capacities so that he is unabashed to report negative findings, where necessary; and he is willing to report his failure to detect clinically suspected trends without feelings of guilt and insecurity. He must realize that his recording cameras, so to speak, are often set at different angles from those of the psychiatrist, and therefore that his picture of the person under scrutiny may look different, and that often the very discrepancy between the two pictures may be important in assessing the total personality.

III. A psychologist may be considered clinical when he has lost his experimental rigidity sufficiently to realize that at any moment more relevant material may be elicited in relation to a particular patient by a complete break in or change of technique; when he knows that the rules for administering a test are not ends in themselves; when the detailed recording of a single failure to a given problem becomes of paramount importance and is never dismissed as an item merely "not completed in the allotted time;" when he is willing to replace the demanding quantitative deity he has worked for as an experimenter and at whose feet he has poured endless libations of statistics by the humble, qualitative hunch; when he is willing to give full weight to a single slip of the tongue in an answer, despite its correction to one which is technically acceptable.

IV. A psychologist may be considered clinical when, before he utilizes a new test instrument, he is willing to see himself as primary source material, subjecting his own performance to the scrutiny of a recognized expert; when he can refrain from envisaging his own performance as the norm, or the good,

or the center of the universe from which all others deviate, so that all persons resembling himself are automatically whitewashed and those most sharply deviant in personality type considered more seriously disturbed; when he is willing to take a good look at his own weaknesses, to seek out his own blind spots, and to relate these inadequacies to his evaluation of the personalities of others; when he ceases to have, or preferably, has never had, the attitude that a psychologist is in essence a glorified examiner, a being apart, a deus ex machina, an individual forever sitting in judgment on some sort of sub-species, the patient; when he is willing to say, with John Bradford in the 16th Century, "There, but for the grace of God, go I."

V. In the fifth place, a psychologist may be considered clinical when he has sufficient perspective to select the relevant type of investigation for the problems presented by the particular patient; when he has made sure that he can relate his findings to the actual problem confronting the physician; when he has assumed some responsibility for the education of his medical colleagues in areas which, though routine to him, are new to them; when he will present, whenever possible, copies or samples of the specific performance of his patient, and allow himself only the types of conclusions and generalizations which can be understood from the material which he presents. Most important of all, when he is able to communicate his findings in an intelligible fashion, without recourse to high-sounding technical cliches from textbooks, the meanings of which he is actually uncertain of himself. This problem is, to my mind, all-important. Slowly, in the course of attempting to bridge a gap between disciplines, one realizes the tremendous waste in meaning which takes place. Nowhere is the psychologist's anomalous position more clearly demonstrated, or the failures in a medical education which leave out some type of psychological orientation more clearly shown. The psychologist resorts to technical jargon largely because he is unable to say in plain English what his findings mean, even to himself. He has had, that is, a textbook orientation and lacks real clinical experience even in his own field. He is afraid to use medical terminology because he feels insecure and self-conscious in it.

Let me caricature a not unusual comedy of errors. The scene is laid in any hospital in which the psychologist is attempting to find his place without having clearly before him his goal, his responsibilities, a knowledge of his place on the team. The intern, who has been asked to have the patient examined psychologically, translates these instructions into, "I want an I.Q. on this patient; they're going to discuss him on ward rounds." Since the intern has had no training in psychology, this vagueness is inevitable. The psychologist takes this request at its face value, and reports correctly, but in this case misleadingly, "I.Q., 100," without explanation of the all-important additional fact that "there is a considerable amount of scatter between the sub-tests."

The intern, ignoring the last sentence, reports at ward rounds, "The patient is normal; psychological examination negative." A psychiatrist in the group may look skeptical and ask if a Rorschach has been done. The intern (this is in the days before the famous film, *The Dark Mirror!*) makes a note to "get

a raw something done" or alternatively, "one of those shock tests." The psychologist administers the Rorschach, and again speaking in his foreign language reports, "This patient shows W, 20%; D, 20%; Dd, 60%; F—, 50%; no M or FC; color shock on Card II." This technical monstrosity is read off by the intern next day, and needless to say, no one is any the wiser.

At this point, two psychiatrists may disagree with regard to the patient's relationship to reality, and the psychologist is asked point blank to pronounce him either neurotic or psychotic. On the spot, and feeling grossly insecure, he remembers Rorschach's pronouncement that when color shock is found in a record, there can be no question of a psychosis. He makes a blind stab and pronounces the patient neurotic. When the patient several days later is transferred to a psychiatric hospital, the intern feels justified in remarking, "I certainly can't see any point in getting a patient psyched; first they say the man is normal, then he's neurotic, and all the time the guy's nuts!"

Ten years ago, the spectacle of the psychologist knocking for admittance at the pearly gates of the medical world was a novel, if not a startling, sight. It evoked frankly raised eyebrows among psychological colleagues, who saw one as a renegade, automatically lost to science and research. The medical St. Peters who cautiously opened the door were kindly and tolerant, but were puzzled as to what to expect from or offer to their lay visitor. Even the psychologist himself was none too sure of his mission, for without the household word of psychosomatic medicine or the concept of the projective techniques, his place in the hospital set-up, his mode of attack on problems, was nebulous. To those of us who experienced these groping, tentative, but challenging years, the sudden shift of the wheel of fortune which has precipitated Clinical Psychology into the position of a vocational best-seller is almost breathtaking.

All over the country, as we know, universities are trimming their courses or augmenting their catalogs to meet the growing demand of students for systematic training in this field, and as a result, academic psychologists without hospital experience and with no orientation whatsoever in the field of therapy are having incongruous demands made on them. It is clear that we are at an important point in the development and crystallization of a profession. Clinical Psychologists are in demand, and in future they will arrive at the scene of action with the knowledge that they are specifically trained for the task at hand. Clearly, the *relevance* of that training is all-important; and to my mind cannot come from a psychological orientation alone. It must include the ideas, criticism, cooperation, and support of our medical colleagues.

PRE-CLINICAL TRAINING OF THE CLINICAL PSYCHOLOGIST

CARLYLE JACOBSEN
Dean, State University of Iowa, Graduate College

MY contribution to the program of this conference can best take the form of a survey of current practices for the training of clinical psychologists. In making such a presentation it is important that one keep in mind the kind of person who is expected to be the product of such training. In the past, and at the present time, the psychologist in the team of psychiatrist, social worker and psychologist has made a major contribution in the area of research as well as carrying certain clinical responsibilities. I would regret any program that does not provide good training of the psychologist in the area of research. It is one of our present vantage points and one of our major areas of contribution. I feel we should continue to exploit this advantage. It is quite possible that we will wish to see further specialization as between the individual whose primary responsibility will be in the area of research and the individual whose primary function will be in the area of clinical service. The training programs for these two groups of persons may indeed require quite different content and approaches. It is worth noting that as of the present time many of the major research contributions in the field of clinical psychology, and certainly from the point of view of psychology as a basic medical science, have come from psychologists who have been trained primarily as investigators, not as therapists. While it is possible in some instances that these two talents and interests will be combined, I suspect that it will more usually require different individuals. In planning a program for the training of clinical psychologists, I think it is important that we do not lose sight of the fact that we still need a Ward Halstead and others who have come to clinical investigation from the psychological laboratory, as well as needing individuals who would be trained primarily for the practice of therapy.

In offering these comments on a training program for clinical psychologists, may I emphasize the danger that is involved in crystallizing the pattern of training too early. Clinical psychology is far from having its task completely formulated or its status in the clinical team clearly defined. Certainly we do not know the precise training that will produce most effective individuals, if indeed there is any single program that is either essential or adequate. My comments, therefore, should be looked upon as suggestions and as a reflection of training programs now in operation, perhaps not in any given institution but crystalized from a number of programs in various institutions. One word of further explanation—in recent years medical schools have increasingly dropped the long list of prescribed courses and have been content to say that its students shall be trained in certain basic areas of study. In my comments, I hope that the various subject matter listed in the several areas will not be looked upon as course designation, but rather as areas of knowledge that ought

to be built into the competent scientist or clinical psychologist who wishes to work with people in health agencies.

At the undergraduate level it is perhaps convenient to group the training under the following major headings: the biological and physical sciences, the social studies and the humanities. In part, it is a reflection of my own background in training and to a greater extent a certain acquaintance with the field of medicine that causes me to emphasize the need for broad training in the biological sciences. Man is an organism and man's problems in part derive from the fact that he is a biological organism attempting to adapt to the environment in which he lives. It seems essential that the prospective clinical psychologist shall have had training in general zoology and, for my choice, additional training in the field of general physiology. In order to handle work in general physiology adequately it is necessary that the student shall have had adequate background in physics, chemistry and mathematics. Certainly as biology and psychology become more quantitative in their approaches, an adequate foundation in mathematics has become increasingly essential. It does not seem unreasonable that the student would devote approximately twelve hours to work in the field of biology and another thirty hours of study in the areas of physics, chemistry and mathematics.

Turning next to the area of the social studies, a knowledge of the basic materials in the field of sociology and anthropology, in economics and in political science, would appear to be a minimal requirement for the individual who is going to work with people living in our present social order. In addition to this training in the area of the social studies, one might well ask that the student, as an undergraduate, have an introductory course in psychology and social psychology and that he have a course in statistics and a course in experimental or physiological psychology as part of his undergraduate training. This study in the area of the social sciences would require from 24 to 30 semester hours of work, or essentially the equivalent of one full academic year.

Not only for its contribution to the general education of the prospective clinical psychologist, but for its value in dealing with and understanding the problems of patients and for knowing the world in which we live, the minimum of a year to a year and a half can well be spent in the area of English, including the technical aspects of composition, in literature, history, art, music and foreign languages.

The task outlined here is no small undertaking. With some measure of choice left to the student's special interests, four years of study will be required.

Let us consider next the program of the student at the graduate level. He is presumed to have had an introduction to psychology, social psychology and some acquaintance with statistics and introductory experimental psychology. The program at the graduate level can well begin with a consideration of some of the so-called fundamental courses in psychology, courses that should be similar to the basic science courses offered to the student in medicine during his earlier years. In arranging programs of study, it is a desirable pedagogical

technique from the point of view of interest, and I believe from the point of view of sound training, that the student shall from the outset have work in the area of his principal interest, namely, clinical psychology.

A knowledge of the history of psychology, particularly of modern psychology, seems to be fundamental if the student is to have any reasonable background for his advanced study. At the University of Iowa such a course explores the major, modern systems of psychology. Likewise, some understanding of the philosophy of science seems essential to a person who proposes to become a scientist and apply the scientific techniques which he will learn. If such courses are to be effective, it is my opinion that we will require teachers who are more adequately prepared than many who now offer such courses in the history of psychology. At Iowa we have been fortunate in having as our professor in this area of study a man who was thoroughly trained in mathematics and in the logic of science and who has also been trained in the area of social study, especially of law, who has been analyzed and who knows dynamic psychology through his own personal experience and work in this field. Such an introduction to the history of psychology and to the methods of science gives a good background upon which to build the later techniques and skills that are to be offered to the student. Such a course could well occupy from three to six hours of study (note that 30 semester hours per year represents a full schedule of study in the Graduate College).

The area of developmental psychology, of advanced social psychology and of dynamic psychology might well occupy from nine to twelve hours of work during this first year. It would be in such courses that the student should come to know current theory of personality structure and development, and something of the problems of adaptation to the social world in which we live. In addition to this training in the area of dynamic psychology, it is essential that the student acquire during his first year of graduate study a firm grounding in the theory of measurement and the design of experiment. One of the major activities of the clinical psychologist in his work as a member of a team will be concerned with measurement of ability, attitude, interest and capacity. It is reasonable that he understand the statistical and mathematical background and assumptions that underlie the tests and other evaluating instruments which he will use in his study of the patient. Such a course might well require from three to six semester hours of work, depending in part on the manner in which other courses are arranged in the individual department. Finally, in the area of background or basic courses, I would like to include work in the psychology of learning and in experimental psychology. Much of the activity of the clinical psychologist is going to be concerned with the problem of learning and relearning, of modifying attitudes, of helping the patient to restructure habit systems. Certainly it is desirable that the student have some grasp of learning theory and of the technique and skill involved in re-education. The work thus far outlined would embrace approximately four-fifths of the student's time during the first year of graduate study. The final segment of time, approximately six semester hours might possibly be devoted to what we may call the

introduction to clinical psychology. In such an introduction to clinical psychology, I would hope that the student would first of all learn something of the responsibilities that come to the individual who proposes to help with other people's problems. He should learn of his relations to the patient and of his relations to other professional members of the team. These attitudes and points of view should be foremost in the mind of the student from the very beginning of his training as a professional psychologist.

It is also encumbent on the neophyte to learn in a practical way of the simpler techniques which he will be called upon to use as a clinical psychologist. As part of his introduction to clinical psychology he should know something of the way in which the Binet Test or the Bellevue-Wechsler Test are constructed and the way in which they are used in the study of patients. This should be not merely a theoretical or didactic instruction but should include a *clerkship* type of training given in the clinical center. The prospective clinical psychologist should also be learning at this time something of the art and technique of the personal interview. He should learn the importance of record keeping and the ways in which records are preserved and used for analysis. The student should learn something of the report which he will be expected to make in writing to other members of the team or to social agencies, and the manner in which he can most effectively present his material at staff conferences. Finally, the student would learn to review and evaluate his own experience with a particular case in the expectation that he will learn from his errors and successes and will develop the attitude of criticism toward all of his activities.

It will be a busy year for the student and lest the summer go to waste, I would recommend that the prospective clinical psychologist devote it to an *introduction to social case work* as taught in some competent school for the training of social workers. I would like him to understand the point of view and the technique of another member of his team, not with a view that he would become a "jack of all trades" and try to carry the task of the social worker as well as of the clinical psychologist, but so that he may know the problems and the approach of the social worker. He will be a better clinical psychologist for this experience.

The work of the remaining three years in the training program of the clinical psychologist should place the major emphasis upon the clinical skills and the point of view that are necessary for the future work of the student. During the second year, three or four areas of work should be covered. First, there should be a course in advanced psychological measurements which would include theoretical and practical training in the projective techniques, in the measurement of special disabilities, the evaluation of vocational aptitudes and interest, and the measurements of attitudes. Allied with this theoretical preparation there should be a practicum course which would give the student opportunity to apply the skills and techniques at the point at which service is rendered to the patient. In so far as possible, the practicum course should give the student opportunity to serve in a psychiatric unit, on the neurological

service, in general medicine and pediatrics. As opportunity offers it is desirable that the student have practicum experience working in a school system, in a vocational counseling unit of a university guidance program, and in the work of one or more social agencies dealing with community problems. These two courses would well occupy at least one-half of the second year of graduate study.

It is essential that a clinical psychologist who is to work effectively in a health agency should have an acquaintance with some of the problems of the physician. He should understand basic concepts and should appreciate the therapeutic problem which the general physician faces in addition to understanding in greater detail the problem of the neurologist and the psychiatrist. Such training on the clinical services of departments of medicine, neurology, psychiatry and pediatrics can well occupy the twelve to eighteen semester hours of the student's time.

The third major activity of the second year could be an introduction to therapeutic techniques. Psychologists should know reading disabilities and the ways in which reading skills can be improved. It would be useful for him to know something of the techniques of speech training, of vocational counseling, and where the relationship is favorable between psychologists and medical personnel, it would be well for the prospective clinical psychologist to have his first introduction to psychotherapy during this second year. For those students who are unable to get this phase of their training started during the second year, selection of the internship should be arranged so as to provide for training in psychotherapy. Again we find that we have given the student a well-filled year of work.

At some time during the student's four years experience, it is essential that he have a year of internship. In many instances, it would be most advantageous to take this year of supervised experience as the third year of a four-year graduate program. The student should have acquired sufficient skill to handle his basic techniques, to understand clinical problems, and to know his way about in a clinic or hospital organization. He should be capable of carrying on the ordinary routine with a minimum of supervision. He does need, however, a good measure of the chastening influence that comes only through having to apply, evaluate and learn from making one's own errors and from achieving success.

As graduate instruction is presently ordered in most institutions, in most graduate colleges, the student for the Ph. D. degree is required to prepare a thesis. Preparation of this thesis should be the equivalent of not less than one-sixth, and in many instances up to one-third, of the student's full graduate program. The fourth year would be devoted in large measure to preparation of the thesis. Indeed, it should be possible for the student to outline and plan his thesis during the latter part of the second year, and if the student's internship is accomplished in an institution sympathetic to research, it might be possible for the student to gather certain basic data during part of his internship

year. The second major activity of the fourth year would consist in seminars and advanced courses in the field of psychology, education, vocational guidance, sociology, anthropology, and in psychiatry and other medical disciplines. Secondly, these should be cross-discipline seminars so that the student has opportunity to participate in the exchange of points of view between the several areas of study.

In outlining a program such as this, I think it is important that we allow for some measure of elective work on the part of the student, although frequently this elective work can be accomplished in part of the student's thesis or in the seminars of the fourth year. It should be possible for the student to develop some special interest or talent which he may possess.

The program which has been considered is oriented primarily toward the training of students who will serve in the role of clinical psychologists in a health agency with emphasis upon the service to patients. For those whose special strength will reside in the field of investigation, it may be desirable that they plan theses that will be more rigorous than the thesis of the clinical psychologist.

There will be few in the field of clinical psychology, as it is now constituted, who would be happy to see the training reduced below the level which has been here indicated. It is a long program and, in certain respects, one that leads to limited vocational opportunity. It is hoped that this presentation will give some understanding of current practices in the training of the clinical psychologist and serve as one point of departure for the later discussions of this conference.

TRAINING FOR THE CLINICAL APPLICATION OF TEST TECHNIQUES

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THE figures which Dael Wolfle got together for President Walter Dill Scott on the extent to which psychological tests are used, are impressive but at the same time frightening. For those of you who are not regular readers of "The American Psychologist" this statement is I suppose somewhat cryptic. I am referring to a recent statement by the Secretary of the American Psychological Association. Dr. Scott inquired as to whether Wolfle could tell him how many tests had been given to how many people in the United States. After some study, the latter came up with the figures, for 1944, of 60 million standardized tests administered to 20 million people. Of these, 25 million had been given to approximately 4 million in the armed services.

The tests done in the clinical setting though *relatively* small in this astronomical context are *absolutely* quite great and probably carry the most important practical implications. One sees here a reasonable basis for the concern existing in several quarters about the part which these procedures inevitably play in determining the direction of psychological development; concern about the dangers associated with placing tools of this kind in the hands of technicians, that is, in the hands of persons who, from the standpoint of the academic group, have no real foundation in a discipline and who, from the standpoint of the clinical group, have no real understanding of the setting in which they are to be used.

It is the recognition of the needs as well as the dangers of the situation which has led to the recent emphasis on professional training in clinical psychology, training which is directed towards the development of competence in research and therapy, as well as in test procedures and their application.

In the setting of a program for training in clinical psychology which accepts at least a four-year graduate course, three years at the university and a year of internship, there are two obvious aspects of training in test procedures which should be considered: What is the part to be played by the university; what is the part to be played by the field center? It is the consideration of the high points of the contribution of each which concerns us now.

Training at the University Level

In discussing the university's contribution, I shall limit myself almost entirely to the courses directly related to test training. The University may reasonably be expected to provide the student with his first acquaintance with test techniques. More important, however, it should give him a systematic foundation of knowledge about tests.

This would involve an integrated program of teaching, having these main aspects: description, theory and practice. Without becoming involved in the details of curriculum construction, we can indicate what we think the student should in general have by the time he gets to the internship training center.

He should have a background in the *theory and philosophy of testing.* This would include an understanding of the place of testing in systematic psychology, its relationship to other forms of directed acquisition of knowledge, such as naturalistic observation and experiment, its history in detail, its strengths and weaknesses as a scientific method and as an applied technique. He should have a background in the *theory and practice of test construction,* its psychological aspects, its statistical aspects, its relationship to factorial analysis and other, more psychological, methods of personality analysis. He should have an extensive, if superficial, acquaintance with the wide variety of test devices: intelligence—verbal and performance, individual and group; personality, questionnaire and projective; educational and vocational guidance; sensory and motor; and some general notions about their applications. He

should have a more intensive acquaintance with certain selected devices generally used in clinical settings. Whereas he may have acquired his knowledge of the former from general test survey courses, his knowledge of the latter should have been obtained from specialized courses concentrating on these techniques. And this knowledge should not have been derived from didactic teaching alone or from additional occasional practice on fellow-students. Practicums and clerkships must have been recognized as essential parts of the training, and periods of practice with subjects in clinical settings must have been provided. The general emphasis during the university period should, however, not be on too intensive practice in any one device or with any one type of subject; rather, should it be directed toward the students' getting the "feel" of contact with a variety of types of patients as well as the "feel" of a variety of test procedures. With this in mind the university should have available geographically convenient clinical and other field centers for clerkships, such as schools, child guidance units, feebleminded schools, psychopathic and other psychiatric hospitals, educational and sensory-motor disability clinics, prisons, industral units and vocational guidance centers, among a number of which each student may be rotated.

Training at the Field Level

We have in mind here a period of at least a year spent in an internship or externship. Even if the preparation with which the student comes to the field training center meets the criteria outlined, it is inevitable, and in fact desirable, that a certain amount of the activity at the center is duplicative. The student should at the time he commences the internship have, besides a general background in psychology, a broad acquaintance with test techniques and a beginning appreciation of their application. He has now come to a setting whose major contribution is that it throws him into direct, constant and intensive contact with human material—a setting in which he can apply both his theoretical knowledge and his beginning skills.

In this environment, where the emphasis is on the individual patient rather than the problem or the technique, there are certain goals related to test procedures which one hopes the student will achieve. One hopes that besides acquiring skill, through repeated practice in the administration and understanding of a wide variety of tests, he will learn when tests are called for and when not, what tests and combinations of tests are required in specific problems; that he will learn their limitations as well as their strengths. One hopes that besides acquiring a sensitivity to the diagnostic and prognostic aspects of his test findings he will become sensitive to the therapeutic implications as well. In fact, one hopes that he will go further and develop a "therapeutic attitude" in his testing, will avoid probing and the carrying out of misplaced therapy, and without violating the controls and in keeping with the spirit of good testing procedure he will leave the patient the better rather than the worse for the experience. One hopes that he will acquire some sense of balance between the extremes of rigorous pedantic exactness and sloppy

guessing, that he will recognize that different problems lend themselves to differing degrees of control, that there are times and stages of the development of a problem when a rough negative correlation appears to obtain between psychological meaningfulness and degree of control. One hopes that he will learn that what is important, while working always for reasonably greater control, is to be honest about the degree obtained at the particular time, to admit ignorance and hypothesizing when such are the case. One hopes that he will attain enough security on the one hand not to escape, into exactness about the insignificant and on the other, into meaningless profundities, because he is overcome by the complexity and the difficulties of the significant. One hopes that he will at the same time acquire modesty in the face of these difficulties. One hopes that the student will acquire a sense of responsibility about his findings—an appreciation of the fact that his findings make a real difference to a particular individual and his immediate group, and that he carries this as well as the broader social, scientific responsibility. One hopes he will learn to be constantly sensitive about the research implications of his findings and his techniques, that he will be aware of the inadequacy of the methods, the data and the theory in the field, that he will therefore be on the lookout for significant problems and ways of attacking them in order to tie them up with the fundamental facts of psychology. One hopes he will learn to work closely and in integrated fashion with other disciplines whose essential goals are similar, that he will learn the true value and meaning of the "team" approach to the problems which he meets, problems which require this cooperative attack because of their complexity.

These general goals can more easily be achieved in a large training center where various disciplines are represented and where students from these other disciplines are trained. Too much training in psychology has gone on in starved environments, and there should be a change in this respect. In the adequate training center, besides the appreciation of the many-sidedness of the problem which comes from the different philosophies and points of view which are ordinarily represented, there is a good deal of learning by example from the other disciplines, e.g., an appreciation of rigorous experimentation which is derived from the physiologist and biochemist, or an appreciation of the importance of meaningfulness, as represented in the systematic viewpoint of the psychoanalyst towards molar data.

Before permitting the student to get involved in any testing at the field training center, he should have a period of intensive "soaking" in patient contacts in order to become aware of patients' attitudes and experiences, of what sickness really means to the patient and his family. In the resident psychiatric hospital this is fairly easily arranged, since a period of a week or so on the wards, in the capacity of attendant, meets these preliminary needs. In out-patient clinics and other institutions which do not have a resident population the student should spend such a period in sitting in on anamnestic and other interviews and obtain, in every way convenient, direct contact with patients and their problems.

In the actual process of training for test administration, the student, under close supervision, should be permitted to travel as fast as his background and ability permit him. The general policy is for him to start with the simpler, more controlled and objective devices and work up through a series of steps to the more complicated, subjective ones. Throughout there should be emphasized the need for being sensitive to the evaluation of the patient's attitude toward the examination, the possible handicapping factors, his interest and effort, the representativeness and optimal level of the findings.

With respect to each test device, the general order of *training for examination* consists first in general background reading of the manuals and other pertinent material about the device. This is followed by a period in which the student observes through a one-way screen the administration of the test by experienced examiners. He may then practice on fellow-students and follow this by practice on patients. (In this connection, a state hospital with a large stable population is particularly satisfactory for training since patients are always available for examination and with few exceptions welcome the experience.) This may be done under observation by colleagues, or independently in the earlier stages. A written test on the procedure, followed by the actual examination of a patient while being observed by the supervisor, brings the training period to a close, if these steps are passed successfully. The intern is now presumably ready to administer the particular device independently, subject to the conference review by the supervisor which continues throughout the internship.

Training in the *treatment of test results* follows a pattern whose purpose is to provide intensive supervision during the early stages. After scoring the test results, which are checked for accuracy by a fellow-student, he writes a report which is criticized by one of his more advanced fellow-students. Such student checking and initial supervision, we have found, is very helpful in making students aware of points to which they would otherwise not be sensitive. It makes them more appreciative of the problems inherent in supervisory control and speeds up the process of accepting responsibility. The report is then turned over to the supervisor. It has been my experience that strictness and insistence on high standards for report-writing is one of the most valuable contributions made by the internship. It is also one of the sources of greatest difficulty in the initial handling of interns. With very few exceptions, however, interns are in the end grateful for having had to submit to this discipline, and feel that they have gained considerably in the ability to analyze and organize case material.

The supervisor's responsibility in this respect is of prime importance. It is not his task to check reports for simple errors in technique or arithmetic. These, with few exceptions, are taken care of by a student checking system. Rather is it the supervisor's task to criticize the evaluations made by the intern, to consider points which have been missed, or wrong interpretations, to indicate ways in which the exposition of the findings is inadequate, and ways in

which they can be made more adequate. After mutual consideration of these points the intern rewrites his report and returns it for further criticism. The supervisor may insist on as many rewritings as he deems necessary.

From the description of the clinical psychometric program here given, it will be seen that considerable dependence for its successful outcome is placed on the quality and amount of supervision provided. Although during the process of training a considerable amount of necessary service work gets done, and it is important that this should be so, the goal of training cannot be forgotten. From the institution's standpoint the investment is worth while, for in the latter half of his internship the student is sufficiently well prepared so that he can make a definite contribution to the institution's needs.

Having gone through this preliminary period of test training for some of the simple devices the student, as soon as possible, is permitted to take his place in the routine examination of patients, starting with the simpler problems and working up through the more difficult. While he is carrying this responsibility, he is at the same time going through the training process for the more advanced and difficult tests and as he becomes ready can set up more and more complicated batteries of tests. It is important, however, to keep the student under control and prevent him from rushing ahead too fast or reversing the natural order too much. It is common for students to wish to get on rapidly to the study and use of the Rorschach and TAT without previous thorough training in the simpler devices. The reasons for the delay, namely, the importance of extensive clinical experience as well as technical accomplishment for the proper use of such devices must be made clear to them.

The student should be encouraged to carry out the examination with a minimum amount of information about the patient. The basic descriptive data, together with the problem as it exists for the psychiatrist referring the case, should ordinarily be the only knowledge available for the initial examination. If other definite problems turn up during the examination, these may be followed up. The results are written up and only then should the case record be consulted. The relationship of the psychological findings to the psychiatric, physiological and social data may be evaluated separately. The report should consist of several sections: an analysis of the test results which should contain an objective account of the test findings and behavior of the patient during the examination; this should be followed by an evaluation and interpretation of the findings as they relate to diagnosis, prognosis and other factors; recommendations for disposition may be made if these are called for by the problem or the findings.

When he has reached the stage of taking part in the routine examination of patients and usually after he has organized his report, the intern is encouraged to discuss personally with the referring psychiatrist (usually the resident) the findings and their implications. We have found this to be one of the best points of contact between the students in the two disciplines and an enriching experience for both.

In the early stage of the internship, the student depends upon some senior member of the staff to report his examination results at staff conferences. As he attends more and more conferences and becomes increasingly proficient in his testing, he is gradually led into reporting at conferences, starting with the simpler diagnostic conference, and toward the end of his internship period, reporting at major teaching conferences. In this way he is given, increasingly difficult administrative functions and is actually learning to carry a staff member's responsibilities.

With regard to the extensiveness of the experience which the intern may be expected to go through during the course of a year, it has been our experience that a program which involves the examination of between 100 and 150 cases is about average and as much as a student can handle, considering the other demands on his time. This, of course, refers to his direct examinations. A good deal of his test experience comes from indirect contact with additional patients through the reports of other examiners during conference, personal discussion or supervision. This experience should have included as extensive a variety of patients as the institution possesses but the emphasis should be on the intensive study of fewer cases rather than on mere numbers for number's sake. There is a certain advantage, however, to experience in screening—very short contacts with a great variety of cases, and if such experience can be provided it should be considered as a desirable part of the training. Whenever possible there should be an opportunity for work with normal subjects, employees or others, in order to help the student maintain a norm for judgment and to understand the factors which go into the making of normality as well as of deviance.

Concurrently with the testing of patients other activities having direct relationship with the testing program take place, such as seminars on case material in which the test results on particular patients are examined in detail both for themselves and their relation to the findings of other disciplines, or seminars in which new developments in test theory, procedure or norms are considered.

Besides the activities mentioned there are others, less directly, but no less significantly, related to the test program. I refer to the acquaintance which the student makes with clinical psychiatry through attendance at case conferences and didactic lectures, his experience with interview and therapeutic techniques, and his participation in research activities. These relationships, I trust, will come out in other presentations.

SUMMARY OF THE DISCUSSION

KUBIE: Many important questions have been raised this morning concerning undergraduate education for clinical psychology: How long must such training last? How long should one aim for? What concept of duration gradually should evolve? What do we train for? Is the initial goal of basic training to prepare a man for practice, as in medical schools, or is the primary purpose to be to train a man for teaching and research?

Here it might be well to consider the experience of those medical schools which have tried to place the emphasis largely on training for research and teaching rather than for practice. This has never been an absolute distinction, but it has led to certain curricular differences. For instance, for many years there was a deliberate plan of this kind at Yale, where every student had to do a piece of research as part of his own training. This question of fundamental policy will come into our deliberations on the basic curriculum for clinical psychology.

Another troublesome and basic problem brought out in the discussion was the question of *when* in any curriculum it is best to teach what human beings are like. This is a fundamental issue in the evaluation of all teaching in this field, since the emotional maturity of students depends on the answer.

We began with the issue of what should or should not go into the undergraduate curriculum. This brought up many difficult and complicated problems such as, the question of motivation, the question of how early a man matures, and how early he loses that obsessional indecision, characteristic of adolescence, and also how he handles that obsessional indecision. It was pointed out that there are youngsters who handle this by plunging impulsively into a quick pseudo-decision; that this often is a premature and unrealistic decision, which may, nevertheless, color their whole lives. So often the adolescent thinks he knows what he wants and goes directly after this goal only to be disappointed when he reaches it. Other youngsters handle the underlying indecision by postponing the decision indefinitely, sometimes using that intervening time profitably for broadening their horizon, and sometimes wasting it. The problem of how to deal with these two extremes and the many intermediate mixtures involves basic educational issues, a full discussion of which could take the rest of this conference.

Attention was called to the fact that the age issue is also complicated by economic problems, some temporary, others permanent. The relative maturity of the Veteran-student today tends to obscure to some extent the issue as it will challenge us in the long run.

More fundamental is the problem of motivation. The group recognized that some of these motivations are relatively superficial, such as identification with a particular teacher of psychology. Here it was pointed out that whereas doctors appear as objects of identification early in everybody's life, psychologists appear late, if at all. Therefore identification with doctors can carry all the confusion of early childhood; and identification with a psychologist may have a more mature but less deep basis.

Consideration of pre-clinical training also brought up the question of whether it is better to give a student a broad base in the humanities or a highly specialized base in the biological sciences. Here again comments brought out the point that one cannot make any all-inclusive generalizations, because some youngsters develop like a pyramid on its broad base and some like a pyramid on its head. For instance, there are physicians who as students lived in a scientific ivory tower but who after emerging from the academic setting develop broad, social and cultural interests. These variations must be taken into account in any flexible educational scheme. A related point was brought up as to whether undergraduate education should provide technical skills or simply serve as a selective screening device.

Here the discussion moved on to certain more specific problems, especially to the question raised by the last two speakers; i.e. what, after all, is a clinical psychologist? It was surprising that this did not come up until the end of the morning. I had thought we were going to face it in the first sentence and that it would probably stymie us for at least a day. I am glad, however, that it came up so late; if we arrive at an adequate formulation of that by tomorrow afternoon, we shall be doing well. The formulation which Dr. Rosenzweig suggested consisted of two complementary components: (1) the dynamic psychology of personality on the one hand, and (2) the applications of specific methodologies to diagnosis, treatment and the analysis of personality on the other. This is a good start.

The question has also been raised as to whether the clinical psychologist is not being lured into therapeutic quagmires by social need, and whether in the long run he will not serve society and science best by resisting that lure. This is a most difficult problem. In the first place, it is not easy to turn one's back on an acute social need, especially because of the inadequacy of the medical school system to meet this need. Also it is difficult to forget these therapeutic needs because of the emotional dilemma in which every man who deals with human beings who are suffering, finds himself. How can we plan an educational program which leaves out therapy entirely when the human beings, who are going to implement that program, will be confronted constantly with human needs for which there are no community resources? Sooner or later a lot of them will be forced to attempt to fill that need. We cannot wholly shut our eyes to this simple fact, even if we should like to on purely theoretical grounds.

The question came up (and it is an important one) as to what precisely is the relationship between therapeutic and research activities in psychology.

The point has been made repeatedly that in all medical research, clinical maturity is usually regarded as an important foundation upon which to base mature research. It is easy then to apply the analogy, and to say that in clinical psychology, clinical maturity would also be a necessary basis for mature research. This may be true; or it may be that the relationships are different in clinical psychology so that there can be a division of labor. This is a question about which certainly no one can jump to any conclusions. Some felt that if the clinical psychologist is lured into the therapeutic field, he becomes a "professional" in an applied science, and loses the objectivity and scientific detachment which research requires. We face that problem in medicine all the time and it will come up in some of the further discussion and in the papers which will be presented this afternoon, this evening and tomorrow.

I should like to add here that I failed to mention the contribution of Drs. Spitz and Piotrowski: Of what should the basic scientific teaching really be comprised? How much of specific science, statistics and mathematics and how much formal methodology of logic? How much general scientific reading? How much technical training in statistical evaluation, etc.? I wanted to remind you of this because it places before us an alternative to the curricular outline which was presented to us this morning.

MRS. GINSBURG: I should like to say a few words in response to a question raised by Dr. Kubie in regard to the training of psychiatric social workers: Which do you make first in your professional group—practitioners and then investigators or teachers, or is it vice versa?

In social work we have always made the practitioners first. They, in turn, with experience become the teachers in the field. Now the field and the schools together are becoming dissatisfied, not with the sequence of making practitioners first but because of a recognition that a two year course makes only a fairly adequate beginning practitioner and that it is becoming increasingly difficult to include specialization in the two years. This thinking has grown out of function, out of the needs of the field.

In relation to Dr. Kubie's other question about shortening or lengthening the training of psychiatrists and clinical psychologists, I might say that there is a growing feeling in social work that the course will eventually need to be lengthened, with two years as the basic training period and the third year for specialization. For some time in the past and more and more in recent years, we have seen the development of third year work, during which experienced workers seek to improve their skills in supervision, teaching, administration, research, community organization, etc., and we may one day find that specialization in any field of social work will find its way into the third year. For some time, too, universities have given doctorates but they have been very few and are usually granted in one of the related sciences, not specifically a doctorate in social work.

The 1946 Annual Report of the American Association of Schools of Social Work noted that three students had earned doctorates during that year. We know of many more who are now taking advanced work and can expect that the trend will develop, although we do not know at what rate.

THE TRAINING AND FUNCTION OF A PSYCHIATRIC SOCIAL WORKER IN A CLINICAL SETTING

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IF I may speak for my psychiatric social work colleagues at this meeting, I should like to say that our presence here is evidence of the clinical teamwork that has long characterized the three professions which comprise this conference—psychiatry, clinical psychology and psychiatric social work. Throughout the developing history of the out-patient psychiatric clinic and particularly the child guidance clinic, we three have worked together, each contributing from his special area of competence, each carrying his share of the work load. The relationships and responsibilities have not been static; they have shifted and changed constantly during the past quarter century; and today, as a result of war-time acceleration, are more volatile than ever. There is much talk of realignment of treatment and other responsibilities; psychotherapy and who may practice it is discussed whenever two or more members of the related professions meet; the new and obviously satisfying responsibilities which war service thrust on many of us are not easily relinquished. But it is evident, as these new developments are discussed, that service to patients in a psychiatric setting requires and will continue to require the collaborative efforts of all the professions comprising the clinic team.

Regardless of how current confusions—many of them semantic, others basic—are finally resolved by studies now underway or contemplated, each of the professional disciplines will continue to bring to the clinical setting a specific orientation and competence. In the case of psychiatric social work, the orientation has been clarified through years of experience. The psychiatric social worker has a community responsibility and a continuing concern for the social factors in illness that are clearly defined. By training and experience the psychiatric social worker is a member of a professional group which works under psychiatric leadership. In other words, the function of the psychiatric social worker in a psychiatric setting, while it has many component parts, is directed as a whole toward contributing to the psychiatrist's diagnostic and treatment efforts and toward helping the patient and/or his family make maximum use of the services of the clinical setting. A clinical setting is a *psychiatric* setting; the patient is the psychiatrist's patient; psychiatric social work is an adjunctive profession serving the *psychiatrist's* patient. Responsibilities may be delegated to adjunctive professions by the psychiatrist, but the ultimate medical responsibility for the patient who is emotionally ill, remains

with the psychiatrist. This premise, which is basic to psychiatric social work training and function, is not so elementary as it may appear at first glance. Much of the current confusion about "who does what" in a psychiatric setting results from lack of clarity about this fundamental concept of the clinic team.

Any discussion of psychiatric social work training and function must begin with function, which, in all of social work, has preceded—and shaped training. The social worker has always had to act, to serve, to deal with people who had problems. Helping came first; the need to understand people and their problems grew out of experiences in the helping process.

In 1917, "Social Diagnosis", by Mary Richmond presented the thinking of a very young profession. For fifteen years Miss Richmond had gathered data, studied agency records and interviewed social workers in an effort to synthesize that which could be taught to young people going into social work. She stressed understanding, sympathetic interest, helping the client to help himself and many other aspects of human relationships that are no less valid today than in the early years of the century. But she had only yesterday's tools to work with and fact-gathering was stressed: collateral visits, investigations, reports, letters, etc. However, even with this rather legalistic approach we see ". . . social evidence may be defined as consisting of any and all facts as to personal or family history which, taken together, indicate the nature of a given client's social difficulties and the means to their solution." Service to the client was the reason for social diagnosis and our first curricula in schools of social work grew out of experience in the field.

As professional knowledge and skills developed they in turn influenced function. Increasing competence invites increasing responsibility and more diversified performance. This interchange between the field of practice and schools of social work continues, reinforced equally by each new development in our society which demands new skills of the social worker and by scientific advances in our own or related professions upon which the schools can draw in their preparation of social workers.

Social case work is practiced in a variety of settings, each requiring a basic professional competence which can be adapted to the special needs of the given setting. A good family case worker does not become a medical social worker merely by joining the staff of a hospital social service department. To his basic skills in working with people he must add much medical information, much more than he now knows about the emotional and social factors in illness and must re-orient his thinking from that of a social agency to that of a medical institution, its personnel, professional relationships and function. Or a psychiatric social worker moving from the clinic to a child placing agency finds himself, with all his generic skills and diagnostic equipment, obliged to orient himself to a non-medical agency which is concerned with investigation of foster homes; placement and supervision of children; work with parents and their feelings about the child's relationship with foster parents; work with foster parents about their feelings toward the child and his parents; and with

the child who is frequently the confused recipient of many different, conflicting feelings and attitudes to which he is reacting. The client group and the function of the agency determine the specific nature of the case worker's function.

We are concerned here with psychiatric social work which is defined by the American Association of Psychiatric Social Workers as "social work undertaken in direct and responsible working relationship with psychiatry. It is practiced in hospitals, clinics, or under other psychiatric auspices, the essential purpose of which is to serve people with mental or emotional disturbances." Since the psychiatric social worker's precise function is dependent on the setting, it will be different in a mental hospital and in an out-patient clinic. It will also differ from adult clinic to child guidance clinic and from an out-patient clinic in a general hospital to a community mental hygiene clinic not under hospital auspices.

For our purposes today I should like to outline briefly the function of a psychiatric social worker in a child guidance clinic that is not a part of a hospital out-patient service or school system, in other words, the typical child guidance clinic which accepts referrals from the community and has no intake restrictions other than age limits and diagnostic criteria.

The psychiatric social worker participates in the two general functions of all such clinics: service to patients and community relations. Actually, for the psychiatric social worker, even more than for the other staff members, the clinic's community relationships are an integral part of the daily job.

The typical referral from a social agency, for example, begins with a telephone call which is taken by the psychiatric social worker who discusses the situation with the referring worker and determines whether or not the clinic is in a position to be helpful to this child. In each such referral contact, the worker is responsible for interpreting the clinic and its function so that the referring source will understand the reason for acceptance or rejection and gradually come to use the clinic for the service which it is best equipped to offer.

As happens often in the early years of a clinic's existence or when staff turnover in agencies decreases the number of workers in the city who know the clinic, the referral may be inappropriate. In discussion of this child's problem and the community resources available for alleviation of the difficulty, the clinic worker endeavors to assist the agency worker to a more appropriate referral.

Gradually, as the community learns about the clinic, the referrals become more appropriate and the initial telephone call is usually followed by an interview with the parent in which the intake process is carried a step further. In the course of this interview, the worker may find that the particular problem is actually much more serious than appeared to the referring source and one with which the clinic is not equipped to deal; that the problem presented by this family situation is more appropriately the concern of another agency in the

community; or that the family is already making use of the services of another resource. The possible variations are numerous but the responsibility of the psychiatric social worker to the patient who cannot be accepted by the clinic remains the same: to make the rejection as constructive an experience as possible for the parent and the child and, when indicated, to refer them to the appropriate resource.

If the interview with the parent reveals a situation which falls within the clinic's function the psychiatric social worker has several responsibilities: to interpret the service which the clinic has to offer; to orient the parent to the clinic so that he will know and can help the child know what to expect and, equally important, what is expected of him; to conduct the interview in a manner designed to explore the presenting problem, the parent's feelings about seeking and accepting help, as well as social and other factors in the situation.

In staff conference or through other administrative channels, the psychiatric social worker contributes to the clinic's total understanding of the patient's needs out of his knowledge of the social, environmental and familial forces as they may have influenced the patient's attitudes, behavior and general adjustment. And from contact with the parents, the worker also contributes his estimate of the degree to which they can be helped to achieve more desirable attitudes toward the child and his problems. Each member of the clinic team contributes from his own area of competence to the total understanding of the situation and all participate in staff planning for treatment under the psychiatrist's leadership.

The psychiatric social worker carries treatment responsibility under the supervision of a senior worker and consults with the psychiatrist as indicated by the nature of the situation and the treatment plan. This may include case work treatment of the parent or other responsible adult, in close cooperation with the staff member who is treating the child—either the psychiatrist, the clinical psychologist or another psychiatric social worker; or a treatment relationship with the child, while the parent is treated by another member of the staff. In either event, the case worker usually has contact with community resources which might facilitate improvement in the child's general adjustment as a member of society: the school, a recreational agency, medical services, a family agency, camp or other seasonal resources and other agencies or services as indicated, as well as the original referring source. In other words, the psychiatric social worker's activity is designed to help the patient and his family make the best and most effective use of the service which the clinic offers as part of the whole constellation of community services.

Thus from intake to the closing conference, the psychiatric social worker is concerned with the community of which the clinic as well as the patient is a member. The clinic is a member of a complex network of agencies and services. It cannot treat children in a vacuum but only as it takes its place among all the social, educational and health agencies in the city and serves

a purpose which supplements the total program. For a new clinic, much depends on the ease and rapidity with which the working relationships can be established. The service which the clinic is able to give, the role it wishes to play in the community can be stated at the outset but must be restated with each referral and in each contact with the community. The psychiatric social worker carries much of the responsibility for these relationships.

This is the skeleton of the basic psychiatric social work job in a child guidance clinic. Depending on the experience of the worker and the needs of the specific setting, there may be added: Training of students in psychiatric social work; contributing to the education and orientation of students in the other two disciplines; consultation service to other agencies; participation in public education—talks to lay groups, seminars, institutes, etc. in cooperation with other members of the clinical team; research—in relation to the total research program of the clinic; and, of course the team work sharing and learning that goes on daily in a child guidance clinic.

The training of the social case worker is oriented throughout to the professional responsibility which he is to carry, beginning with preprofessional undergraduate courses. Related preprofessional work is not "required" in a strict sense but with the enormous increase in candidates for admission to schools of social work it is becoming one of the criteria for selection. Today few applicants are admitted to schools of social work who have not taken an approved preprofessional sequence with a major in one of the social sciences, plus other related courses. The American Association of Schools of Social Work has prepared a leaflet entitled "Preprofessional Education for Social Work" which lists the courses that are considered likely to be useful to social workers, but emphasizes that:

> "The exact title of courses and the number of courses included in the preprofessional sequence are not important. Much more important is that the sequence include the following content:
>
> 1. Principles of human association: Social organization and development of social institutions and interactions of individuals and groups; cultural patterns; normal family relationships; individual and social deviations.
> 2. An understanding of human motivations; physical and psychological development of the individual; group behavior.
> 3. The elements of statistical analysis and interpretation.
> 4. The economic organization of society: wealth and its distribution; labor in modern industrial society; economics of consumption; public finance and taxation.
> 5. American government; federal, state, and local organizations, functions, powers, and interrelations.
> 6. An introduction to the philosophy, principles, methods, processes, and organization of the social services."

We are also finding that an increasing number of undergraduates who are majoring in the social sciences, are having volunteer undergraduate placements in social agencies as a beginning orientation to the field. In New York City five colleges have worked out arrangements of this kind for their junior and senior students with excellent results. Not only does this experience have screening value as to the individual's aptitude for and real interest in social work which is later useful to the schools of social work, but it has proved to be an excellent guide for the students in the crystallization of their occupational choice.

While it is recognized that educators are averse to narrowing the range of undergraduate education and focusing it too directly on a future vocation, there are certain advantages in an early clarification of educational choice. One of these is obviously financial—the need on the part of many young people to become self-supporting as early as possible. If the undergraduate experience can include a fair amount of work in the liberal arts and can also begin to focus the student's occupational interests, the young person is less likely to find himself unprepared for next steps in reaching his career. It might also be added here that in much of rural America many people are going into social service without graduate training of any kind. With an eye to the welfare of our fellow citizens who come in contact with social services throughout the country, we must consider the ultimate benefit to the greatest number that is to be found in at least the beginnings of preprofessional orientation to social service.

Another factor frequently taken into consideration by the schools of social work is the amount and kind of related work experience following the completion of undergraduate work. The schools are interested in candidates whose work in the social or health field has led them to seek graduate training and have traditionally welcomed such students.

Graduate training in psychiatric social work is now offered by 16 schools which are accredited by the American Association of Schools of Social Work and which provide a psychiatric social work curriculum approved by the American Association of Psychiatric Social Workers. Since sequence is of prime importance in the evolution of a case worker it is not enough to list courses or subject areas alone when attempting to present the training of a psychiatric social worker. For this reason I should like to quote a portion of a report by the Committee on Psychiatric Social Work of the Group for the Advancement of Psychiatry—Dr. Marion E. Kenworthy, Chairman—which is concerned with a sample curriculum in a school of social work offering psychiatric social work specialization.

"In order to complete his training and to receive his master's degree, each trainee must complete courses in the following areas:

I. Courses in Social Treatment.

These include basic case work, advanced case work, child welfare, advanced family and psychiatric social case work, courses in medical

information, and a series of at least three courses in psychiatry, which include: (1) a course on the development of personality (normal development) from infancy to old age, (2) behavior disorders of children, and (3) psychopathology. Elective courses including the problems of delinquency, clinical psychiatry, etc., are taken.

II. Courses in Social Research.

These include studies in social statistics, social investigation, and current problems in social research.

III. Courses in Public Welfare and Social Insurance.

Such courses as The Child and the State, Public Assistance and Public Welfare, Social Insurance are required.

IV. Courses in Economic and Social Legislation.

Introduction to Industrial Relations, The Law and Social Work and Minimum Standards of Living.

V. Courses in Community Organization and Related Fields.

"During the *first quarter of instruction,* the student's program contains:

1. Basic Case Work Course I. This material is presented in the form of Case Discussion. (36 hours).

2. The course in the Development of Personality (18 hours—given by a psychiatrist).

3. Medical Information (18 hours—given by a physician, with emphasis on the psychodynamic implications of the subject).

4. Supervised Field Work in a family agency, public or private (20 hours a week for 12 weeks—240 hours).

"From the beginning the student is taught to understand the individual—how he feels about his problem, how he feels about asking and accepting assistance.

"In the beginning courses, cases are presented dealing with the problems of relatively normal individuals with relatively adequate ego structures.

1. At this point in training, the course in the development of normal personality is taken concurrently.

2. It is necessary for the student to understand the importance of social stresses and their relationship to emotional upsets.

3. It is recognized that the student must become aware of the value of prompt and adequate, therapeutic help as an important preventive measure.

"In the process of studying eight to ten cases in his first quarter of instruction, the student becomes aware of the specific services which any given social agency provides and the effective use of community resources when they are available.

"He further learns the elementary principles of interviewing, he becomes aware of the confidential nature of the professional relationship, and he begins to develop an awareness of some of the dynamics involved in therapy.

Content of *Second Quarter Instruction*:

1. Social Case Work II (36 hours).

2. Behavior Disorders of Children (18 hours—given by a psychiatrist).

3. Supervised field work in the same family agency as the first quarter (240 hours).

"In this twelve-week period, cases are studied which are selected from a variety of social agencies, designed to present a range of problems, such as illness, physical handicaps, disturbed family relationships, cases of unmarried mothers who need assistance in planning for and deciding about the future of their babies, the problems presented by runaway adolescents, etc.

"In this quarter, the major change in case selection is directed toward emphasis upon the more emotionally disturbing issues involved in the individual's social problems.

"Much emphasis is placed upon a better understanding of the elements involved in the action-interaction problems of family life. In all of the teaching cases, social problems are present which require specific services, i.e., financial assistance, arrangements for medical care, use of vocational guidance, rehabilitation service, provision for placement of children, special school arrangements, etc.

"In the *third and fourth quarters,* the following courses are required:

1. Psychiatric Social Work I and II (36 hours—given by a psychiatric social worker).

2. Psychopathology (18 hours—given by a psychiatrist).

3. Field work in a mental hospital or a psychiatric clinic setting (child guidance or adult)—480 hours, with intensive case work supervision by a psychiatric social worker and a psychiatrist.

"Cases selected for treatment in these two quarters are chosen from psychiatric hospital or clinic settings. Broad opportunities are made for a discussion of the work of the clinical team and the place of the psychiatric social worker in this team.

"In the *fifth quarter,* emphasis is placed upon psychiatric field work —240 hours—with more intensive emphasis upon extension of treatment processes and the beginning of a research project in psychiatric social work.

"In examining these patterns of progression, the feature of sequence is particularly noteworthy.

"By the time the student comes to his specialization in psychiatric social work, he has achieved, (1) some understanding of psychopathology; (2) achieved some medical information; (3) has had considerable experience in helping people, through his basic understanding of the dynamics involved in the helping process; (4) has acquired a familiarity and understanding of ego strength and weakness, the mechanism of defense and a broader awareness of the psychodynamic factors involved in interpersonal relationships.

"In the pursuit of his special field work training in the psychiatric clinical team work, we see him acquiring:

1. A deeper understanding of human behavior.
2. Increased knowledge of psychopathology.
3. A more adequate understanding of the emotional elements of family life.
4. A deeper understanding of the patient-worker relationship, and its management.
5. A more effective professional contribution to the psychiatric clinical team work.
6. A more adequate selectivity in the use of community resources."

As I have indicated, this is a sample curriculum which represents the exact sequence and correlation of class and field work for only one school. But while the curricula of other schools may differ from this sample in varying degrees, those which have been studied and approved for psychiatric social work specialization by the American Association of Psychiatric Social Workers are found to comply with the standards set by the Committee on Professional Education of the Association.[1] Psychiatric social work as a specialized field is elected by the student at some point during his first graduate year, at the completion of which he may undertake specialization.

In a psychiatric field work placement, the second-year student continues to develop the skills that are basic to all social case work and to adapt them to the special needs of the setting. Under close case work supervision, the student gradually begins to function in each of the psychiatric social work areas of responsibility noted earlier. Cases are selected which fall within the student's slowly increasing competence. The severity of the problem, the size of the caseload, frequency of supervisory conferences, the kind and number of community contacts, and the degree of treatment responsibility are all dependent on the student's progress as gauged by the supervisor through recorded material and conferences. Equally important to the student is his personal and professional orientation to the psychiatric setting, its organization, its personnel, the professional relationships within the clinical team, the contribution which each discipline can make to the total program.

In conclusion, I should like to underscore what I believe to be some of the distinctive characteristics of social work education. Classroom work is of two general kinds: one, informational courses geared to the job which the

student will be called upon to do at the completion of training, the need for which has been demonstrated by the experience of practitioners in the field; and secondly, the seminars in which case material from agencies is discussed by students under case work leadership not only to implement skills and assist them in becoming more adept at the application of theory to practice, but, equally important, to aid in their achievement of that less tangible objective, a professional attitude and approach.

The field work placements that continue throughout the two-year course serve many purposes beyond the obvious one, that of learning by doing. Correlated with the classroom work by the close working relationships between agency supervisors and school faculty, the field work experience can be adjusted in content and pace to meet the individual student's needs. Under supervision the student gradually becomes aware of himself as he is helped to focus his attention on the client and his needs, to accept, to understand, to see the client's use of the worker and his own responses and feelings. Cautiously, lest the student be hurt in the process, the supervisor helps him recognize his own feelings, his prejudices and blind spots, his impulse to give or to withhold, his need to be liked—the feelings and attitudes that make him the individual that he is. This awareness of self, not the self-consciousness that afflicts young students, is essential to the professional equipment of a psychiatric social worker. Its achievement is not marked by clearly defined milestones. As Dr. Herbert Chamberlain assured an eager student who wondered how you could tell when you had it, "It's rather like the measles, you wake up one morning and there it is."

Social work educators and supervisors are familiar with this phenomenon; yesterday a fumbling, self-conscious novice, today a relatively mature professional person who accepts responsibility for himself in relation to clients, co-workers and agency. From that point, he goes on, under supervision, to consolidate theory and practice with increasing competence. This then is the fundamental objective toward which the entire educational process is directed: the worker's disciplined use of himself in the process of helping others to help themselves.

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ELEMENTS IN THE MEDICAL CURRICULUM WHICH SHOULD BE INCORPORATED IN THE TRAINING OF THE CLINICAL PSYCHOLOGIST

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IN considering what aspects of the customary medical training can usefully be included in the curriculum of clinical psychology, let us first review the job description of the clinical psychologist. It would seem that the rational way, which is not necessarily the best way, to begin planning the education of a clinical psychologist is to determine for what tasks you are training him. I would gather that there is general agreement that the three functions of diagnosis, research and therapy are the particular ones upon which we expect members of this profession to concentrate. For the purpose of argument let us assume that psychotherapy is a proper function for the clinical psychologist, because otherwise the problem of developing a curriculum would not be difficult enough to justify a two-day conference.

The best evidence I can present concerning what clinical psychologists actually do in a medical setting comes from the institution which I know best, the Veterans Administration. We have recently collected some rather inadequate statistics from the first returns of a monthly report system which we hope will indicate to us with increasing accuracy as the months go by, exactly what tasks are delegated to clinical psychologists in the VA. In the month of February, out of a total of 33,855 working hours put in by full-time and part-time clinical psychologists, consultants and trainees, 16,097 hours were spent in diagnostic work. Of this time the largest part was devoted in the hospitals to administering the Bellevue-Wechsler and other objective intelligence tests; in the out-patient clinics the majority of this time was spent in Rorschach and other projective testing. Secondary evidence was put upon the projective tests in the hospitals and upon the intelligence tests in the out-patient clinics. In February 2,709 hours were devoted to therapy and 2,867 hours to research. We do not know precisely how these two functions are interpreted by each of the different field stations, but we are sure that there is great variation in the use of the terms. The rest of the time of VA clinical psychologists in February was spent in teaching, administration, screening nurses and attendants, and certain minor duties.

If we accept these as the functions for which we are going to train clinical psychologists who work in the medical setting, we have some basis, perhaps, for deciding the relative usefulness of various sorts of preparation for such duties.

In proceeding to plan curricula we should also view those duties from another angle. We should ask which of all the different services performed

in hospitals and clinics should be delegated to each profession in the clinical team. What are the services performed for neuropsychiatric patients? Well, it is a long list, including: arranging for intake; determining the chief complaint; obtaining the present history; taking a physical and psychiatric anamnesis and review by systems; getting corroborative history and other facts from the patient's family and friends or from institutions with which he has contact; performing physical and neurological examinations; determining the mental status; requesting or performing indicated medical laboratory tests; carrying out necessary psychological examinations; making a diagnosis and a prognosis; conducting therapy; conducting occupational, recreational, physical and other adjunctive therapies; doing research directed toward improving available clinical techniques; arranging for disposition of the patient; doing case work with his family and friends; and following the patient's later course for purposes of further treatment, obtaining records, and research.

Those are standard operations. They are not necessarily the only services that should be carried out. Concerning this there is a great field for debate. We could do a great many things for and to human beings. Among ways for curing mental illness that have been seriously recommended by "professionals" are: that we read the patients' palms; that we shave their heads; that we bathe them in champagne; that we leech them; that we convert them; that we read to them the Encyclopedia Britannica or "Forever Amber" or Dale Carnegie; that we irradiate them with cosmic rays; that we teach them Esperanto; that we give them singing lessons; that we indoctrinate them in Yogi discipline; that we cut them into the shape of an Aztec sacrifice either actually, for the purification of the soul, or with mirrors.

Now, these are not all foolish ideas, though a good many of them are. In deciding about the job functions of the clinical team, it seems to me that we must realize that we usually hold pretty conservative concepts as to which of the things that can be done with human beings will relieve their neuropsychiatric disabilities. In this we are not necessarily correct. It might be well to train therapists to carry out some of these other functions. Certainly there are many ways to approach the human being, as the choreographer observed to the manicurist. There would be a good deal of disagreement even in the group here present as to which of the techniques of care I have mentioned belong on the legitimate list—and which are illegitimate.

Whatever methods are employed, the issue still remains as to how they are to be distributed among the professions of the neuropsychiatric team. Up to now, this decision has been made usually in an arbitrary manner. To remedy this, I believe that, in our theoretical and rather idealistic discussions of the moment, we might well accept the guiding principle that individuals of each profession should have the opportunity to do whatever they are adequately trained to do.

It is certainly unnecessary for a person to be adequately trained in all the fields that border on his function. Medicine, for instance, borders on

dentistry and embalming, but physicians do not receive adequate instruction in either field. An arbitrary division of function has resulted in medical schools providing their students with little study in dentistry, but much training in otolaryngology, which is just a few millimeters removed from dentistry. The two disciplines are equally important in the study of the total human organism, but tradition and a few practical considerations have decreed different emphases for the two fields. The present division of duties is sometimes rationalized by explaining that function and disease of the ears and throat are more severe and more closely related with other parts of the body than are function and disease of the teeth.

Similar practical considerations may be important in determining what each member of the neuropsychiatric team will do. It may be that, like late wedding guests, the newly arrived clinical psychologists will get to choose only among the pieces of cake left by those arriving less tardily—and there are still plenty of pieces, as is the case at most weddings. There is no reason to fight over crumbs in such a situation.

It seems quite clear to me that we cannot at this moment say anything conclusive about the ultimate division of neuropsychiatric labors. The final pattern will evolve after experimentation in many clinics and discussion by many groups such as this. Since we do not now see the pattern in clear outline, I do not feel that it would be particularly useful at this point to make any detailed recommendation about which specific pre-clinical or clinical medical courses should be included in the curriculum of clinical psychology. Judgment about this will follow almost automatically from our decisions about what clinical psychologists are to do.

It may be profitable, however, to review rapidly and in general terms what clinical psychologists are being taught at present. We have made a survey, which is not wholly accurate for a number of reasons, of universities cooperating with the Veterans Administration in training graduate students in clinical psychology this year. This represents 22 of the 24 universities accredited by the American Psychological Association to give training for the doctorate in this field. A number of points of interest emerged from this study. First, the universities unanimously put major emphasis upon research and the writing of doctoral dissertations by all candidates. In this, of course, they differ greatly from most medical schools. The occasional medical school that does require theses based on original work, puts no great emphasis upon them. This disparity of requirements symbolizes the difference in orientation of medical schools and the departments of psychology giving training in clinical psychology. Much emphasis also is placed on academic requirements for the doctorate in psychology, such as written and oral examinations; few practical examinations are required, and they do not have the major importance which such matters do in medical schools. The common requirement that graduate students in psychology must demonstrate command of two foreign languages before receiving the doctoral degree is difficult to change; in some universities the

departments of psychology would vote to abolish this requisite, but do not have the power, largely because they are part of the same graduate school as the departments of modern languages. A similar situation does not exist in medical schools.

It is interesting to observe that a good many universities list courses on projective techniques; the relatively large number of such courses is rather illusory, however, since several have been inserted in catalogs within practically the last few minutes, and frequently constitute the epitaph of some outstanding member of the department. The group of studies which includes experimental psychology, advanced statistics, history of psychology and systematic theory is required of graduate students by all the universities, which means that the basic emphasis in these departments has not yet changed from the old academic tradition. The presentation of many of these courses, however, is changing markedly because of the new clinical demands. Such clinical or pre-clinical subjects as psychiatry, neurology, physiology, neuroanatomy, and speech are listed by some universities, but usually they are given in other departments or graduate schools, and are not well integrated into the curriculum of the departments of psychology. None of these courses are yet required in the training of clinical psychologists in any of the accredited institutions, and it is interesting particularly to observe that clinical psychiatry is given little emphasis. Perhaps this is because abnormal psychology is offered by all the universities. Abnormal psychology and clinical psychiatry include approximately the same subject-matter. The difference usually is that one is taught by a psychologist who has had little clinical experience and the other is taught by a psychiatrist who has had chiefly clinical experience; one is taught from books, the other from cases.

To this present training of clinical psychologists the medical curriculum can make contributions which can best be stated in terms of general knowledge and attitudes rather than specific courses. There are important viewpoints and understandings which medical students obtain and which, in general, psychologists up to now have lacked. First of all, there is the feeling of responsibiliity for human beings called by physicians the patient-doctor relationship, which has not been part of the academic tradition. Second, an understanding of what children, men and women are like as observed in the clinical situation—which is a sort of "testing of limits" of the endurance of humanity, how people withstand trauma and anxiety; how flexible they can be, and how rigid; how they face trouble, illness, and death. If psychologists have learned this in the past, it has been wholly on their own, rather than in any planned atmosphere where such facts become obvious. Third, there is the recognition of one's own mortality and humanity; of one's failings and shortcomings; of the fact that one harbors in himself pathology, not only physical but mental, and that he must make allowance for this in his own behavior and in his interpretation of others. Fourth, there is understanding of the complexity of clinical problems and sympathy for the task of the clinician. Many psychologists have been ridiculously rigorous in their demands for precision in clinical research because

they have not had any direct experience with it. Fifth, there is comprehension, arising by experience, of the possibility of diagnosing and curing without knowing why the diagnosis is correct or the therapy successful. Clinical techniques frequently are effective although the mechanisms for their operation are not clear. Every effort should be made to discover why they work, but at the same time they should not be rejected simply because they are not wholly understood. The Wassermann test has worked for many years, but what relation beef heart and the red cells of sheep have to syphilis is an enigma even yet. Similarly, quinine was known to cure malaria long before anyone even had a scientific theory as to why it did. In the field of mental disease this same principle is equally applicable. Finally there is the recognition of the compatability of research and the clinical situation that the two can go arm in arm.

It seems to me that there is an incorrect concept implicit in the discussion which has been current for some time as to whether an internship should be included in the third of the four years of graduate training of clinical psychologists. Practical contacts with patients should be frequent throughout the four years; even in the first, when probably most of the work should be academic, some such contacts should be made possible, so that the attitudes we have mentioned can be fostered and so that the separability of the clinical and academic approaches never becomes an issue.

In conclusion it should be pointed out that there are indications that clinical psychology and psychiatry during the next ten or twenty years will tend increasingly to merge. Psychologists will learn psychiatric methods, and psychiatrists will also be trained in psychological techniques. It seems reasonable to me to expect that in more than one center a graduate school or combined curriculum in applied psychological sciences may be established, in which the medical school and graduate school of arts and sciences together train students, drawing also on related studies in the business school, the law school, the engineering school, and the divinity school. At such centers a program like the following might be arranged to be completed within a reasonable time schedule, but having the serious disadvantage of limiting the length of the early liberal education: two years of liberal arts college; one year of advanced clinical psychology, sociology and cultural anthropology; one year of the pre-clinical medical sciences which would be comparable to the present first year of medical school. At the end of these four years, bachelor's degrees could be granted. Following this the candidate would take the second and third years of medical school, then spend a year in medical and psychiatric clinical work in a general hospital, in a mental hygiene clinic and in a neuropsychiatric hospital. At the end of this time, they would be granted M. D. degrees in psychological sciences. They would then have one year of a rotating psychological-psychiatric internship which would include both practice in psychological diagnostic methods of all sorts and performance of various psychiatric duties—complementary functions of equal status. This would be followed by one year of independent research leading to a dissertation, seminars, and a psychoanalysis. At the end

of this year, doctoral degrees in clinical psychology might well be awarded. Work from this time until the graduate qualified for his specialty boards in psychiatry or clinical psychology or both could be mixed psychological-psychiatric residences, including work with psychoneurotics, psychotics, and psychosomatic patients, and clinical research.

This extensive course would take no longer than present training in surgery, and it would probably attract a fair number of men and women, offering them broad experience and producing two-in-one joint psychiatrist-clinical psychologists, hippogriffs of the mental sciences.

ELEMENTS IN THE MEDICAL CURRICULUM WHICH ARE ESSENTIAL IN THE TRAINING FOR PSYCHOTHERAPY

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Why this problem must be considered

APPARENTLY the issue of therapy is bound to raise its head as soon as we get down to brass tacks about the functions of a clinical psychologist. There seem to me to be innumerable reasons why we cannot duck this problem. I do not pretend that any one knows the answer; but I do not think that we can face our problem adequately if we leave the issue of psychotherapy out of consideration.

There are certain fundamental statistical facts which we have to bear in mind, some of them known to you; but perhaps a few that I will mention may be things you have known and forgotten or have never heard. We all know how few psychiatrists there are. We all know that of the 4,000 in the U.S.A., only about 1,000 practice psychiatry in the community. We all know that the neurotic process and its various manifestations are literally ubiquitous and that the more you do the more you are called on to do, because of the educative influence of your work. As someone said this morning, no child knows that there is such a thing as a psychologist. Therefore few young adults want to be one or to call one in. Yet as soon as they begin to experience what psychotherapy can do, then the demand for it snow-balls. Anyone who has had the experience of giving real psychiatric service, not merely consultations, in any area where it has not been used, knows that in a matter of weeks he is swamped with demands. The minute that you start to give service in this field the demands grow out of hand: and this is simply one of the basic facts of human life that we have to accept. It is the challenge that confronts us.

We also know that the entire American organization for medical education, that is training both for general physicians and for specialists, turns out about 75 psychiatrists a year, which is just about enough to take care of the annual retirement of psychiatrists from practice because of illness, old age, and death. Thus it is true that we are barely keeping up with ourselves. Therefore to say that we can leave it to the medical profession to take care of this whole area of human need is not being honest.

Let us consider the medical school situation, too. In 1900, there were approximately 76 million people in the country; in 1940 135 million, or almost double. During those 40 years what happened in our medical schools? These decreased by one half in about 1910-1912, because of the weeding out of inferior proprietary medical schools around that time. The number of medical students, which was around 27,000 in 1900 dropped to about 10,000 in 1910; and since then slowly crept up to 25,000 in 1940. In other words, we have fewer medical students today than we had in 1900, with double the population. This does not even mean that we have kept a steady stream of 26,000 medical students going all the time. These dropped down to 10,000 and only slowly rose again, with two drops during the years of both World Wars. Therefore we are far behind our needs merely for internists and surgeons. How then can these schools take on the training of all the psychiatrists we need? As you probably know, of the 68 medical schools in the country, only something like 45 have departments of psychiatry, and of these only about 20 are in any sense adequately organized or financed. Many schools which claim departments of psychiatry, have one man who is the superintendent of a nearby State Hospital and who comes in once a week at the end of the fourth year to give the boys a psychiatric show. Thus what we can get out of our present medical system is really not very encouraging.

The community has an interest in this. It has an interest in shortening the training of all medical specialists, as a matter of fact, but particularly in shortening the training of psychiatrists by shedding everything which is superfluous.

There is a basic economic unsoundness in our present system of medical education and especially in the training of specialists and again particularly for the psychiatrists. Consider the age at which we start to practice. The last hundred physicians admitted as students at the New York Psychoanalytic Institute were admitted at the average age of 34 years and 6 months, which means finishing at about 39. They do not become fully mature in their grasp of analytic work for another four or five years; so it is in the forties that a man starts to make what contribution he is able to make to this most universal of all human needs.

What is our life expectancy? Although we are a healthy group when we start, after the age of fifty, our life expectancy drops below that of any other group in the community. The actual span of years then, in which we can effectively use a technique which has taken us forty years to learn, is something

like 20 years on an average. That means that the community benefits by that training for an abbreviated period. Also it means that the period of time in which the psychiatrist can earn a living, can make his old age secure, can accumulate enough money to educate his children, is fantastically brief. When people object to the cost of psychiatric treatment they might well keep this simple arithmetical fact in mind. Therefore, the community has a direct interest in seeing whether it is not possible to train a man to do really sound and intelligent psychotherapy in six years, instead of taking twelve as it does now from the start of medical school. It takes between ten to twelve years to train a man from the time he starts medical school until he becomes in any true sense a psychiatrist with mature psychotherapeutic experience. This is my answer to those who say that the psychologist should not be lured into the field of therapy. I do not think we have any option in the matter at all.

I would urge on you another consideration. There is no profession, no scientific discipline, every member of which can or should be creative in a research sense. No science can live on research alone, in an ivory tower out of touch with the challenge of practical application. Actually science always makes progress by the interaction between the pure and the applied scientist in the field. We constantly check the value and validity of our pure scientific concepts by their applicability. The interplay between the two is an essential and healthy part of training and of the maturation of any science. Therefore, if we are to be realistic, must we not think in terms of developing a para-medical curriculum leading to a para-medical discipline of medical psychology, as Dr. Miller has described? In such a para-medical curriculum all the water will be taken out of the stock, retaining only that which is valuable, useful and relevant to psychodiagnostic, social diagnostic and psychotherapeutic tasks.

So much by way of introduction. How to integrate such a curriculum in a medical school, with the pre-clinical psychology as taught in college, what order should be followed in building up psychological-clinical experience, how long the pre-clinical and how long the clinical phases should take, are all issues about which we have no right to come to any final conclusions. I visualize it as something in the development of which several alternative systems and curricula would be worked out for comparative tests under varying auspices.

The major obstacles to giving practical expression to any such idea should be considered carefully either at this conference or at the next conference. These are (1) the shortage of teaching personnel; (2) the over-burdened teaching responsibilities carried by psychiatrists already; (3) the legal obstacles.

In the development of this general concept of a new para-medical discipline of "medical psychology" or "clinical psychology" to be taught in our medical schools, there are several considerations to keep in mind.

The Essentials of Training for Medical Psychology

1. *Atmosphere*

It is essential for anyone who is to undertake therapy of any kind that he should be familiar with the multilateral phenomena of illness. This means

becoming familiar with the impact of illness on the lives of men and women, of adults, of children, of all ages, and in all economic and social circumstances. It means understanding the way people feel and act when they are ill. It means becoming familiar with the similarities and differences in the way people behave when they are suffering from organic ailments with pain, organic ailments without pain, ailments which carry with them the threat of death, and ailments which are mere respites from the daily chores and responsibilities of life. Naturally at the same time it involves familiarization with the phenomena of neurotic illness.

Towards these many-sided phenomena the good physician develops a special sense of responsibility, one which is quite different from the attitude which the average administrator or teacher or investigator develops. There is a profound difference between administering a certain test to someone who is a healthy young college student and volunteers to be a subject, and administering the same test to someone who is sick and who brings into the test situation the turbulent and varied emotions which sickness can evoke. Similarly there is a profound difference between approaching that sick person as material for teaching, as an object of administrative disposition, as a subject for research, or as a responsibility and challenge to make him well.

There is only one place where this atmosphere and feeling of therapeutic responsibility, this dedication to healing, has been cultivated, namely in medical schools and hospitals, where everyone functions as part of a complicated therapeutic team. This atmosphere is so important in training for therapy of any kind, that without it all intellectual and technical equipment is of little value.

Therefore training for medical psychology and especially its clinical diagnostic and therapeutic phases, should be given in medical schools and teaching hospitals.

2. *Intellectual Equipment*

(a) Self-Critical Judgment

Through centuries of trial and error physicians have had to learn how difficult it is to be objective and accurate in the evaluation of therapeutic techniques. The emotional influences which warp our judgment, and the pressure towards willful thinking can be counteracted only by scrupulous self-criticism. Mistakes in therapy and mistaken evaluations of therapeutic methods are not news to physicians. Skepticism and self-criticism is therefore deep in the tradition of the doctor; and out of this he has developed certain techniques for critically appraising the impressions which any one man may derive from his isolated and limited observations. These consist essentially of: (a) the use of numbers sufficient to make an adequate statistical sample; (b) making sure of the identity both of the individual units and of situations; (c) making sure of the identity of procedures; (d) where identity in any of these respects cannot be attained, making sure that the sample is a true random sample and not weighted in any direction; and (e) finally making sure that the apparent

therapeutic results exceed in numbers and/or in speed the incidence of spontaneous cures, or of cures by other methods.

Habituation to these critical checks, to this general attitude, and to these techniques, can at present be obtained only under medical auspices.

(b) Factual Data

Training in medical physiology should rest on a general basic training in anatomy: but this anatomy can be taught in an abbreviated fashion largely through such modern visual aids as animated drawings, diagrams and transparent and opaque models. It is estimated that instead of the thousand hours which are approximately the number now used to teach anatomy, it could be done easily and well in about 100 hours if such modern devices were used.

Anyone dealing with disease processes of any kind, even those who confine themselves to the psychotherapy of the neuroses, should have some familiarity with the clinical physiology and clinical pathology of organic processes, and with the ways in which these express themselves in symptomatology. In training medical psychologists, the goal of such instruction would not be the recognition of specific disease entities and their differential diagnoses, but rather an understanding of the processes by which the body balances between sickness and health. This would include a sound knowledge of clinical physiology, especially neuro-humoral, autonomic, biochemical, biophysical, cardiovascular, respiratory, excretory, and genito-reproductive. For the medical psychologist, since his subsequent practical and research work would both lie in other fields requiring other techniques, little or no laboratory hours would have to be devoted to these subjects. They could be taught instead through texts, lectures, and again all manner of modern teaching aids. Here again a great saving of time would be possible.

Similarly most gross and microscopic pathology, clinical pathological laboratory techniques, and almost all bacteriology except for the general principles of infectious disease, epidemiology, and immunology could be omitted.

But the essential feeling of familiarity with the phenomena of illness can never be learned from lectures alone. This can come only in one way, i.e., through direct contact with patients and from the slow accumulation of experience which is gained by history taking, and through tracing in patient after patient the natural history of sickness. Consequently a new kind of clinical clerkship would be needed in the training for medical psychology: a clinical clerkship which would not include the making of physical examinations, nor laboratory examinations, but which would include history taking, some bedside nursing care of patients, and the administration of batteries of psychological tests. This type of ward, bedside and out-patient experience should be secured with all types of organic disease processes before undertaking the same type of work on psychiatric services. Only through ward and clinic service of this kind, which would bring the student into daily contact with patients

suffering from a wide variety of diseases, can a psychotherapist be produced who will have a sense of sureness and of at-homeness with patients who are ill. After such training and experience, organic illness will be no news to him: and will never fluster him either into excessive anxiety or too easy dismissal.

After becoming thoroughly familiar with the phenomena of organic disease, the same type of experience would have to be acquired in the wards and out-patient departments of psychiatric hospitals.

This entire curriculum could be completed in five to six years from the time of graduation from college; and could and should at the same time include psychoanalytic training, which could be begun at any time after the work on organic wards was started.

Medical psychologists trained for clinical diagnostic and therapeutic work by such a curriculum would complete their training on an average at about the age of 28. With another two or three years of closely supervised work they would be fairly seasoned therapists, with far more training in psychotherapy than most psychiatrists have had when they take their Board exams, except for those with analytic training.

Such a program as this would make it possible to train many more psychotherapists who would work well with physicians because they would be working together as equals. They would be ready to start using their skill at ages 5 to 10 years younger than do the medical psychiatrists. This would mean more psychotherapists trained at less cost, practicing for more years, more hours available for giving treatment at less cost to patients and to the community. And all of this without sacrifice of safety or of scientific standards.

SUMMARY OF THE DISCUSSION

KUBIE: We began with Dr. Gardner's challenging and illuminating question about what differences there are in the psychotherapeutic process, technique, influence or function of the psychiatric social worker as compared with that of the clinical psychologist, especially when they work together as part of a team. This challenge was taken up by Mrs. Ross who said in effect that the therapeutic function of the psychiatric social worker is to enable the patient to live as fully and as comfortably as possible within the confines of his neurosis, but not to attempt to alter the neurosis itself nor the neurotic structure of the personality. By implication there is a precise difference in the therapeutic function of the psychiatric social worker and that of either the psychiatrist or the clinical psychologist, in that both of these latter attempt to alter the underlying neurosis itself.

Another important point brought out by Mrs. Ross and Mrs. Ginsburg is that the psychiatric social worker is taught to become aware of himself and to utilize this knowledge in the therapeutic relationship. To put it technically, some knowledge of transference and counter-transference and of how to recognize and manipulate these is taught the social worker in order to enable him to use this for its therapeutic influence.

This brought us through the comments of Dr. Brosin and Dr. Krugman to another important distinguishing feature, which has historical roots. The psychologist comes into the field from the laboratory and from academic circles, while the psychiatric social worker comes from direct contact with human needs. As a result psychiatric social workers have been the first group in the community to accept and utilize a dynamic approach to problems of human personality and of human maladjustment. For this reason they have become more sophisticated and more mature than any other group in the use of analytic and dynamic concepts as part of their daily working tools. It is a result of this same historical development that they have a tradition of accepting medical (and specifically psychiatric) leadership and of recognizing the necessity of working as part of a team. Dr. Krugman also emphasized that the very nature of psychiatric social work has tied it closely to field work—in other words, to applied knowledge rather than to theoretical abstraction. Finally, Dr. Fremont-Smith pointed out that outside of analysis few young psychiatrists receive any training in psychotherapy and that psychiatrists, as a group, have failed to be as therapeutically minded as psychiatric social workers. It is important that clinical psychology should aim to attain the virtues of both and to avoid their limitations and defects.

In the discussion following the papers of Drs. Miller and Kubie, several questions were raised. First among these was the question of whether psychiatric social workers who are trained not in medical schools but in their own organizations can acquire the same type of self-critique about therapy as that used by the psychiatrist and clinical psychologist. This was discussed from several points of view. Next the question was raised whether the entire medical curriculum would not benefit from a basic streamlining and shift of emphasis, since at present it fails to meet even the needs of the general practitioner. This led to some discussion of what constitutes the essential components in training for psychotherapy. There seemed to be general agreement that of primary importance here was some knowledge of the personal motivations and aims of those who wanted to do psychotherapy. Also in general it was felt that this self-knowledge would come chiefly through some degree of psychoanalytic training, which must include some personal analysis. It was obvious that this brought us face to face with one of our worst bottlenecks, namely, the shortage of personnel prepared to give this kind of training. There were many subsidiary problems, such as the question of what age is most desirable for training analyses, the duration of such analyses, the auspices under which they should be conducted, the relationship of personal analyses to other formal elements of analytic training.

After all of such basic preparatory experiences, one would have to arrange for adequate clinical experience with the actual practice of therapy under supervision. This again brought us up against the same bottleneck, the shortage of trained people to give clinical supervision. Such training is never given to medical students and rarely even to young psychiatrists in training, except for the analytic institutes.

This led back to a discussion of whether or not we could so change the medical curriculum as to make it possible for general practitioners to give at least some part of the psychotherapy which is needed in the community. To most it did not seem likely that this could answer the problem; in fact if any physician or surgeon were to give much of his time to the psychotherapy needed by 60 to 70% of his patients, he would not have the necessary time to care for their organic medical and surgical needs. If, on the other hand, by increasing the physician's and surgeon's psychological and psychiatric acumen they learn to recognize emotional problems earlier and send such patients promptly to trained psychotherapists, then the physicians themselves will have more time for the practice of internal medicine and surgery. This in turn would relieve the shortage of medical and surgical treatment hours for the community as a whole. The problem remains unsolved at present because for the most part the physician either does not recognize or admit the problem, cannot deal with it himself, or has no place to send his patients for psychotherapy. Thus, any way you cut this cake you are left with a shortage of personnel which must be made up somehow.

It was suggested that there were three alternatives: (1) to retrain physicians to do their own psychotherapy, (2) to train many more psychiatrists, (3) to set up a new para-medical profession, for carefully selected representatives of clinical psychology, of psychiatric social work, of education, and of the ministry, to do active psychotherapy as part of a medically led team. Some protested against the establishment of a new para-medical profession of this kind on the grounds that even if one could train a few thousand clinical psychologists, this still would not make a dent in the total problem. To this it was answered that such newly trained specialists or representatives of a Doctorate in Medical Psychology or in Medical Psychotherapy would not only give treatments, but would also become the nucleus for new training organizations, so that their numbers would increase by geometric proportions. Nevertheless, several believed that it would be better to use clinical psychologists as they are now, with as little emphasis on therapy as possible, and solely for purposes of personality evaluation.

Others felt that the development of a para-medical discipline was inevitable; that there must be lay analysts and lay psychotherapists, but that they should be distinguished from the research psychologists. This position was debated on the grounds that there is no way in which one can sharply isolate and distinguish between research and therapy, because clinical research always implies mature and extensive experience in clinical problems, including especially thrapeutic problems. All organic medical research, for instance, is

constantly influenced from the clinic by therapeutic problems; and it was argued that the same thing is true in the psychiatric field. Furthermore, even though it was agreed that research in clinical psychology meets as great a social need as therapy, and that psychiatrists are doing so little research that others must take it over, nevertheless, several believed that for this very reason the distinction between the psychologist and the psychiatrist in the field of therapy must gradually be eliminated; that since the clinic is needed for mature research and since mature research is needed for the clinic, then both the clinical psychologist and psychiatrist must gradually master the same disciplines and develop the same basic curriculum.

Some argued that the most important way to save time in any end curriculum would be through increased emphasis on specilization within the field, but that this specialization must arise out of a broad underlying curriculum, the nature of which has not been clearly defined.

One discussant raised the question of whether it was possible in any way to shorten the basic courses in anatomy and physiology, and still give the student any degree of confident freedom and familiarity with these fields. The reply to this was that if all the unnecessary courses were eliminated from a para-medical curriculum, there would be adequate time for fundamental courses in normal and pathological anatomy and in clinical physiology, which could be given then as slowly as was necessary and over as long a period as would be required in order to give the student a mature grasp of the topic. At this point further discussion of these issues was postponed until later in the conference.

Evening Session

March 27, 1947

THE ROLE OF TRAINING IN CLINICAL PSYCHOLOGY IN GENERAL MEDICAL EDUCATION

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IN order to speak more clearly about the role of training for medical students in clinical psychology in general medical education, it might be well to state at once that this question is so closely allied to similar questions concerning other disciplines that we had better mention them in order to gain proper perspective, because the potential solutions are probably interdependent.

Some of these questions are: What is psychology and/or clinical psychology? What is the place of psychology in a general (college) education? What is the role of psychology in the fields of education, law, theology, business administration, medicine and engineering? What is the role of clinical psychology in the professional schools, as contrasted to its academic roles? It would be more accurate I think to differentiate between "lay therapy" and clinical psychology since the latter field does not automatically confer competence in the former field. A physician or social worker must undergo special training with or without trained supervision to become a therapist and it seems that the clinical psychologist will probably be forced to pay the same price. To what extent is it a better medium for studying human behavior than other subjects in the university such as sociology, anthropology, history, philosophy or literature? The classics provide us with ample material for studying emotions, motivations, memory, learning, thinking, which are also the subject matter of psychology. Presumably clinical psychology deals with these aspects of human behavior in sick people, bringing to this task the hope of applying more objective methods, orderly design for systematic studies, dispassionate interpretation and deliberate and well verified conclusions. Most physicians agree that the study of man's psychological operations, especially in his intimate interpersonal relations, is important; in this postwar period many persons concerned with public welfare, education, religion, labor relations, etc., stress the same need. There is no doubt about our intensified collective interest. We even think we have sound facts, principles and methods to teach those concerned with man's relation to himself and other men.

The simplest argument for clinical psychology in medical education both as an academic subject and as a practical set of skills to be mastered, is that it helps make a *better practitioner* whatever his specialty may be. Clinical psychology, with experimental methods useful in diagnosis, and promising more widespread usefulness in prognosis, selection of cases, checking on results of therapy, establishing verifiable criteria for symptom groups (syndromes), may be regarded as a part of the physiology of the central nervous system. It is also definitely useful at the more social levels of personality organization and their disorders but its position as a basic science is perhaps easier to demonstrate. It is self-evident that a physician should be conversant with the various grades of mental deficiency, head injury and cortical damage from gas, drowning, anoxia, and methods of treatment. In our mechanical age of violence there is greater need for physicians to be alerted to the more subtle grades of organic deficiency in order to do their job well. The types of cortical injury are multiplying and the hazards more widespread as industrialization and speed take their toll. In organic diseases with prolonged febrile states (Brucellosis?) or other debilitating conditions (anoxia) there is some evidence that the cerebral cortex may suffer organic damage. The practitioner must be aware of the methods by which these important, even if small damages, can be detected and charted just as he uses methods in radiology or hematology. He will seek the advice of experts when necessary but he must be cognizant of the possibilities.

A similar, if less impressive argument, can be made in the fields of the neuroses and psychoses although the increased interest in psychiatry may emphasize the needs in these regions. Systematic portrayal of sound experimental evidence will do much to attract medical students to the study of human relations for the problems will seem less vague and reduce their uncertainties (anxieties). To bring some of the basic human problems within the realm of orthodox biological experimentation may well raise the hopes of many that most human problems are available for study and control.

If it is granted that clinical psychology is a respectable and essential discipline comparable to physiology, then we may ask "How shall these techniques be taught? Who shall be assigned the task? When and where shall it be taught? What will be the principal subject matter?" I have no easy or convincing answers but will venture a few brief guesses.

At present clinical psychologists seem to have three main functions which may or may not be practised by any one specialist: (1) *Diagnostic,* utilizing qualitative as well as statistical quantitative methods in normal as well as clinically sick subjects for many purposes (counseling, vocational guidance, selection, school placement, etc.); (2) *Experimental,* utilizing available methods without the primary purpose of giving service; (3) *Therapeutic,* utilizing the methods by and large which have been thought by some doctors to be the province of psychiatrists.

Obviously, there may be overlapping, but these definitions are offered to stimulate exposition from those concerned.

The clinical psychologists' best and most unique contributions are probably in the diagnostic and experimental fields. If they are true members of a university with reasonably high standards of study and research, there will be relatively little objection to their participation in the medical curriculum, once the usual inertias are overcome. If they are merely poorly trained psychotherapists selling uncertain services in the open market, it is doubtful if they will enlist the support of most educated people, let alone specialists in the field, even though they gain academic and state licensure to do so. Competence, not degrees or license, will determine their value in the long run. It is hoped that the best members of this group will provide adequate safeguards for the maximal healthy growth of their profession. If we wish to create a group of lay therapists we can do so, but there are many alternative methods and these need not impinge upon the strong traditional position of the psychologist as an experimentalist and investigator. As Dr. Shakow said, there is as great a social need for sound investigation as there is for service. I believe Dr. Kubie's plan for training lay therapists, like Freud's, opens a rational pathway which does not cloud the issue.

I would like to see a revised pre-medical curriculum in which it was required that the sciences dealing with man as a person (social being) had much greater representation. Psychology would have a major place here along

with sociology, anthropology, etc. With this enlarged humanistic background and specific introduction to the facts and methods of experimental psychology (including medical psychology) it would be much simpler to teach freshmen and sophomore medical students the basic sciences relating to "man in health and disease" (W. W. Gull). The medical curriculum would also need extensive revision but this is probably inevitable and will be increasingly possible with improved teaching methods (models, movies, film strips, etc.).

Then in the junior and senior years and the rotating internship the student would continue his learning through precept and practice under his teachers as a member of the therapeutic team. He would become as accustomed to social workers, specialty therapists, and clinical psychologists as the past generation accepted nurses and laboratory technicians.

This program will require interested teachers in the medical schools, and these are becoming more numerous. It makes imperative strong, well-organized departments of psychology in universities so that its representatives in the professional schools may have proper prestige and support. Dual appointments are probably desirable in order to cross administrative boundaries with greater ease, and will encourage communication between disciplines. With free communication, the subject matter and means of teaching it will develop and we can expect an harmonious cooperation with mutual benefits to all.

THE ROLE OF TRAINING IN CLINICAL PSYCHOLOGY IN THE EDUCATION OF THE PSYCHIATRIST

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MY assigned subject is *The Role of Training in Clinical Psychology in the Education of the Psychiatrist.* If I may have your indulgence, I should like to talk about a few other things as well.

I seem to belong exactly in the category that Dr. Kubie so accurately described, those psychiatrists who finally qualify in about their 40th year and then in the middle fifties, with a rapidly decreasing life expectancy, are overwhelmed by the demand for their services. I think, therefore, that I do know something about the need for therapists. Like other practising psychiatrists, I see that the need is great and pressing. The possibility of meeting this need is entirely baffling at present.

I, myself, doubt whether an increase in the number of therapists, even to the hundreds of thousands, could actually meet it. The more therapists there

are, the more need for services there will be. We would turn up new problems and more patients would always present themselves, so that I am not myself too optimistic about the mass production of therapists, no matter by what kind of training. The most challenging and pressing task is to understand the causes of neurotic illnesses and to do what we can to prevent them.

I am not at all sure that either the practising psychiatrist or the one who professes psychiatry is going to make the fundamental contributions to these two important problems, that is, to a deeper understanding of the nature of neurosis, or how to prevent neurosis. I do believe that both the clinical psychologist and the psychiatric social worker can make significant contributions to these two problems; perhaps greater than the person who is, by force of circumstance, committed to therapy.

Now, very briefly to come to my assigned subject which, perhaps, can be more clearly stated thus:

What training should the psychiatrist receive in clinical psychology? How should he be trained and what is the proper position of the psychologist in a psychiatric clinic?

The position of a clinical psychologist in a department of psychiatry should be that of a surgical pathologist in a department of surgery, a biochemist or physiologist in a department of medicine or gynecology. As such he should be employed in the following ways:

1) Use his expert knowledge in helping solve the clinical problems of the department.

2) Serve as instructor to the staff in methods.

3) Conduct his own researches.

4) Give occasional lectures and demonstrations to medical students, especially on theory and principles, without any attempt at teaching them the actual use of methods.

In the Payne Whitney Clinic at The Cornell Medical School the resident staff, who are usually appointed for a two year period, are given instructions of this nature. They are taught the general principles of so-called academic psychology; they have some knowledge of memory function, of perception, of gestalt psychology, and at least an acquaintance with the literature of animal experimentation.

During their two year residency they are taught to administer tests to adults and children, under the supervision of the psychologist. The more gifted ones are expected to master a few tests, especially the Bellevue-Wechsler, the Rorschach and the T.A.T. Certainly those young psychiatrists who plan to make teaching psychiatry their profession should be given that kind of training. To instruct them is one of the important functions of the clinical psychologist.

For the psychiatrists who are already graduated and in practice, the problem of their education is part of the problem of postgraduate medical education in which we are still backward. It is difficult to teach overworked, practising psychiatrists new and complicated techniques. But I wish to emphasize the great value of a symbiotic relationship between the psychiatrist and the clinical psychologist if only to lighten the burden of the psychiatrist, to make his work more precise, his diagnosis more critical, his objectives more clearly defined, and to check on his own, too often, intuitive judgments.

A team can be an extremely effective instrument. I should not like to see the clinical psychologist, therefore, turn primarily therapist. By doing so he would lose his most important functions, that of instructor and investigator, and psychiatry would in the end be the sufferer.

SUMMARY OF THE DISCUSSION

KUBIE: The question was raised as to whether adequate emotional maturity was not the essential prerequisite for training in clinical psychology, and if so what part of this could be attained through a more adequate maturational education in schools and colleges. Linked to this was the question of how early in any educational program such maturational influences can be initiated. For instance, to what extent the factual data of clinical psychology, if introduced into the undergraduate curriculum, promote not merely academic knowledge, and the mastery of special skills, but also deeper and earlier emotional maturation in the college student?

This led next to a discussion of the diagnostic role of the clinical psychologist. Some emphasized this as one of his primary functions. Others took an opposite point of view, pointing out that existing diagnostic categories do not have a high degree of validity, and that the function of diagnosis itself is not that important. The point was made that the psychiatrist turns to the clinical psychologist not to be assisted in making a diagnosis, but in search of a deeper and clearer demonstration of those aspects of the processes of thought and feeling which without the psychologist's tests remained hidden from view. Ultimately these microscopic dissections of personality will undoubtedly play an important role in the understanding of dynamics and in the evolution of the more significant diagnoses which we hope to be able to make in the future. On the other hand to seek premature correlations between the findings in existing psychological tests and our current elementary and kindergarten diagnostic categories would merely arrest the development of clinical psychology as a science in its own right.

Several speakers again emphasized this belief that the mass production of therapists would never result in the production of enough clinicians to treat

everyone, and that the major emphasis for the future should be on the understanding of the dynamics of the neurosis and on the technique of prevention. For this reason, some objected to any concerted drive to produce large numbers of psychotherapists, whether medical or non-medical.

These points were argued in detail, the proponents pointing out that the suggested advance would not really mean the development of a discipline of lay psychotherapists, as we have known them, but rather a basic reorganization of the medical curriculum; that much which is superfluous and vestigial would be eliminated, leaving a sound common trunk out of which many specialized therapeutic techniques would develop later. Of these, psychotherapy would be one. It was argued again that such a reorganization could save several years, and still produce mature and competent therapists with a thorough grounding in all the essentials of medical knowledge including the medical atmosphere and medical spirit.

The question of the duration of training was discussed many times. Some pointed out that for clinical research and for diagnostic testing alone, the curriculum would take at least three years, and training for therapy at least another three years; all of this in addition to the four years of undergraduate work. A possible additional couple of years for internships and for special clinical and analytical work would make a total of about 6-8 years after college. This would bring a man to the age of 28 or 30 by the time his training was completed instead of the 10-12 years for the medical psychiatrist.

The discussion turned repeatedly to the question of the selection of men for this training, and particularly of how early men become sufficiently mature emotionally for the various steps in training, especially in view of the fact that psychotherapy and psychodiagnostic testing involves the assumption of a certain amount of responsibility for dealing with profound problems in the lives of other human beings. Some argued that there should be two separate programs: one for training for a doctorate in medical psychology, and the other for training in clinical psychology.

Finally, there was considerable discussion of the techniques and problems of selection and the adequacy of any existing selective procedures for the recognition of such qualities as empathy, rapport, psychological aptitude, etc.

Dr. Hendrick took the position that a new profession of "psychotherapy" would be hard to synthesize. It is not merely knowledge, certain courses, which a medical student acquires. He identifies deeply with teachers and other students, and this experience contributes richly to his professional maturation. It cannot be artificially instilled. For it is a cultural heritage of medicine from primitive times assimilated in medical school and essential to the truly medical personality. On the other hand, it is a lamentable fact that training in perception of the basic facts of psychiatry must await postgraduate years for fulfilment, when the learning ability has already begun to recede.

For these reasons, Dr. Hendrick proposed at the Medical Committee Meeting of The Group for Advancement of Psychiatry, that a special curriculum for the training of psychiatrists should be given in medical school. This would involve some abbreviation of the pre-clinical and clinical courses, and the time so saved would be devoted to an intensive training in psychiatric subjects such as does not exist today. The course could lead to a "Doctor of Medicine in Psychiatry" in four years, or—as in Public Health and Dental Medicine—to a combined degree in five. It would provide enough medicine for psychologists who wish to become doctors of psychology, and sufficient psychology for medical students who wish to become psychiatrists. He recognized that at present such a plan would encounter difficult administrative and legal obstacles, but did not believe these were insuperable.

Morning Session

March 28, 1947

TRAINING IN PSYCHOANALYSIS AND THE DEVELOPMENT OF THEORETICAL CONCEPTS OF CLINICAL PSYCHOLOGY

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DURING the first day of this Conference, psychoanalysis was mentioned only in one context: The personal analysis, it was said, constituted a highly desirable, if not essential, part of the training of clinical psychologists. I should like to take this opportunity to state briefly that I prefer the term didactic analysis, that a didactic analysis to my mind should be distinguished from a therapeutic analysis. In stating that difference, I am aware of being at variance with the views expressed by many psychoanalytically trained psychiatrists, psychoanalysts and with some, not all, references to the subject in Freud's writings: I believe that the didactic analysis should not be less thorough or "complete" than the therapeutic analysis, but definitely more so. It should give the analysand and insight into the dynamics of his behavior and personal conflicts, and insofar as possible, into their origin. It should enable him to use this insight under the changing circumstances of life in the continuous process of adjustment, which includes his reaction to the pathological material to which he will be exposed.

In the present context the word psychoanalysis will be used to designate a body of propositions; in order to indicate other areas of meaning, expressions such as "psychoanalytic therapy" or "psychoanalytic observation" will be used. The term "clinical psychology" is for the purpose of this communication defined as referring to diagnostic procedures based on a variety of tests; no specific definition of "test" being implied.

There seems to be no need to establish the value of psychoanalysis for clinical psychology since at least two of the most important projective tests—the Rorschach Test and the Thematic Apperception Test have been devised by psychiatrists deeply imbued with psychoanalytic thinking.

The first question which presents itself is a very general one: How can psychoanalysis be taught? Our experience is well founded as far as psychiatrists are concerned, who have been exposed to didactic analysis and practice the therapy under appropriate guidance. Their theoretical studies supplement not only their general psychiatric training but also both these experiences; needless to say that they are an essential part of their training.

In answering the question for the training of clinical psychologists we would have to assess in the first place to what extent the didactic analysis is a precondition of any fruitful understanding of psychoanalytic concepts. This is an empirical question and the impressions available seem to me not decisive. There seems to be little doubt that the change in cultural conditions and the change in method of presentation of psychoanalysis has somewhat affected some of the manifold phenomena which are traditionally lumped together under the heading "resistance." I do believe—and here I am sure to be in agreement with most of you—that a didactic analysis is highly desirable, provided it does not mean "an abbreviated analysis." I am aware of the danger of being called a purist in this matter but I consider this as only a slight disadvantage.

However, those who wish to study psychoanalysis, whether analyzed or not, must have at least some first-hand experience with certain types of human behavior that can substitute to some extent for the clinical experience of the psychiatrist. To put it briefly: some close and prolonged contact with either psychotics or small children, or some group of human beings under mental stress, seems to be essential for any fruitful understanding of psychoanalysis.

Psychoanalysis itself can today be presented in fairly rigorous formulation. The biological thinking and the constructs of psychoanalysis can be offered to the student by a discussion of clearly formulated propositions, that rest upon these constructs.

The appropriateness of the constructs themselves, i.e. the meaning of psychoanalytic terminology and thought as a whole, can thus be related to the question of the validity of these propositions. Some are verified to the satisfaction of many observers, some to that of few; some are considered as yet unverified; but we assume that all are empirically verifiable, by rules of

procedure generally accepted in science; and that unverifiable propositions are being excluded.

Psychoanalytic propositions can be related continuously to the clinical and "objective" evidence to which they refer. I should like to stress on this occasion that I am using "objective" evidence here in order to designate two areas: "objective" evidence, gained by experimental procedures on the one hand and by systematic observation outside of the psychoanalytic interview on the other. In addition, many of the findings, which I refer to as "clinical", have experimental character. Psychoanalytic observation, one might say, approximates experimental procedure in many areas, but not in all. In any one case of psychoanalytic therapy a large number of verifications and falsifications of hypotheses is repeated; any interpretation given to the patient, whether it proves to be "correct" or "incorrect," is based on a hypothesis that has been put to the test.

In presenting psychoanalysis in terms of sharply formulated propositions related to empirical evidence the teaching of psychoanalysis offers an added challenge; the semantic and systematic clarification upon which such a teaching is bound to be based will gradually reduce or eliminate some of the present controversies.

Psychoanalytic propositions tend to support each other, i.e. through their relation to some basic assumptions they form a system or a *theory* of psychology, both normal and abnormal; a theory that is subject to continuous change and is not equally well-elaborated in all directions. This latter fact determines to my mind the relation of psychoanalysis to the concepts of clinical psychology.

When the clinical psychologist tests *performance* or *isolated functions* of thought, perception or motility, (i.e. in the sense of psychoanalysis: ego-functions) he deals in an area that has only recently been subjected to psychoanalytic observation. Here psychoanalysis offers only a loose set of propositions, that may supply a frame of reference, but that is hardly apt to allow for hypothesis detailed enough to be useful to the clinical psychologist; this will be especially true if the continuum of abnormal and normal functions traditionally tested is extended to include supernormal functions or performance. In this vast area then psychoanalysis might gradually be able to adopt findings of clinical psychology. Many psychoanalysts are interested in estimating concretely what specific functions and performances of their patients have been influenced by the therapeutic process. Moreover, it seems that the various methods of quantification which clinical psychology is using and will develop may exercise a healthy influence on the psychoanalytic clinic; thinking in terms of quantity, and comparing intensities being an essential part of any dynamic approach.

The situation changes when the functions tested by clinical psychology are seen as part of the total personality and its basic conflicts. Psychoanalysis is the psychology of human conflict, and the set of propositions dealing with

this area is elaborated in considerable detail. However, the use of these propositions by clinical psychologists meets with various difficulties of which I shall refer to one only:

Psychoanalytic propositions can be divided into dynamic and genetic propositions. Dynamic propositions describe an existing conflict in terms of an interplay of forces, genetic propositions describe the origin of this interplay as a result of life history. The material of clinical psychology yields access only to a cross section of behavior. The clinical psychologist will therefore tend to focus his attention on dynamic propositions. This may tend to impoverish the structure of psychoanalytic propositions. In speaking of obsessional compulsive symptom-formation, for instance, the psychoanalyst has a set of both dynamic and genetic propositions in mind; he has certain expectations as to the formation of these symptoms in certain patterns of life history; the same is true of expressions such as oral or of anal-erotic behavior pattern. The clinical psychologist is likely to disregard the connection between the cross-section to which he has access and the longitudinal expectations relevant to the psychoanalyst. Here lies a potential danger that might result in the growth of two separate kinds of languages and an increase in semantic confusion.

Didactic analysis of the clinical psychologist may afford a certain protection against this danger. However, it seems questionable whether this protection will be lasting. It seems to me that it should be supplemented by an intense cooperation in research. Sooner or later, test records covering the critical phases in the life history of subjects at least from childhood to late adolescence, but possibly including even earliest childhood or infancy will be available. The clinical psychologist will then deal with the development of trends. At this stage the danger of a division between the dynamic and the genetic approach will be reduced. At the same time some lamentable gaps in the genetic propositions of psychoanalysis might be closed: We might finally learn in great detail how the development of ego functions, gifts and talents of an individual is related to the area of his conflict. Such a coöperation seems to me valuable particularly for one reason: I feel that our knowledge in the area of dynamic and genetic problems of psychology is in a stage in which too rigid a division between techniques, diagnostic or therapeutic, and research is, to say the least, premature.

THE ROLE OF TRAINING IN PSYCHOANALYSIS IN THE DEVELOPMENT OF RESEARCH IN CLINICAL PSYCHOLOGY

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IN formulating my idea on the subject assigned to me, I have, like all of you, first looked for a definition of "Clinical Psychology." I have found it in Announcement No. 33 of the United States Civil Service Commission, Washington, D. C., announcing an examination for appointments to Clinical Psychologists. It reads as follows:

> "Clinical Psychologist. — Applying psychological principles and techniques to the diagnosis and treatment of maladjusted individuals, including administering and interpreting tests of intelligence, achievement, vocational aptitude, or personality, or using other diagnostic techniques; carrying out psychotherapeutic treatment as directed by psychiatrists, conferring with psychiatrists, physicians, social workers, and other professional staff members; contacting individuals or representatives of schools or other institutions to secure information as a basis for diagnosis; performing psychological research in the field of mental health; collaborating in the preparation of informational material; and informing and educating the public by radio and personal addresses."

On the basis of this definition we can divide the fields for *research* in Clinical Psychology as follows:

(1) Research in treatment
(2) Research in diagnosis
(3) "Pure" research

1. *Research in Treatment*

Starting on the assumption that treatment in clinical psychology will be applied to cases up to now treated by psychiatrists, we may assume that the criteria applied to treatment in psychiatry will also apply to clinical psychology. Psychiatry is a medical discipline and in medicine research on treatment originates by and large with the therapist. Under the therapist's guidance, advice, control, a number of non-medical scientists from as widely divergent fields as chemistry, pathology, physics, pharmacology, etc., have collaborated in an ancillary capacity.

A similar arrangement appears to be desirable in psychiatry where all of the above named and many others have already contributed. To these will be added the psychologist, expert in different fields of testing, measurement, statistics, interview, etc., the expert in group investigations and the social worker.

2. *Research in Diagnosis*

The team work suggested as desirable in treatment is a requirement for diagnosis. Here in the best of our hospitals this team work has already become a reality. It has become so unavoidably. The highly specialized investigative techniques of the psychologist are just as much beyond the capacity of the average psychiatrist as the Wassermann, the A.Z., the E.E.G., the X-ray investigation, etc., are beyond the scope of the average practitioner. Every good psychiatrist will be familiar with T.A.T., the Bellevue-Wechsler, Rorschach, and others. But it takes three years to develop a good Rorschach diagnostician alone and we cannot expect the psychiatrist to add this exacting field of study to his already overburdened training schedule.

3. *"Pure" Research*

Finally there is the "pure" research to which we will come back further on. It is not necessarily in immediate contact with patient and treatment. But, as we will see, it is in need of psychoanalytic principles for its orientation. And like all "pure research" it has the tendency to entail conclusions which became relevant in treatment and diagnosis.

From this description of the fields of research assigned to clinical psychology it must be evident to all of you that I am envisaging the Clinical Psychologist as one of the collaborators on the psychiatric team, an opinion also expressed by a number of you. As a collaborator for the psychiatric team the psychologist must possess thorough familiarity with modern psychiatric thinking, with that approach to problems of human psychology and psychopathology which is commonly called the "dynamic" one. It has been stressed and I subscribe to this opinion that "dynamic" is an inadequate description of modern psychiatric methods; beyond being dynamic, the approach has also to be a genetic one; in other terms, the approach to which we refer is the one provided by a thorough knowledge of psychoanalysis.

With very few exceptions the academic psychologist's training offers no opportunity for such study. The reasons for this deficiency are manifold, not the least of them being the small number of qualified teachers of psychoanalysis available. How necessary on the other hand such training is, becomes evident if you consider the origin of those very methods, those investigatory devices which have become most relevant for present day psychiatry. I speak of the projective methods and the batteries of tests.

That psychiatric tests originated from the collaboration of a physician, Simon, with a psychiatrist, Binet, is in itself not surprising—though it is surprising that they were the first ones to apply to practical purposes principles developed many years before by Galton, an anthropologist, and by psychologists, Ebbinghaus and Catell—and it is indubitable that in the fields which academic psychology reserved to itself, education, psychometrics have as important a function as in psychiatry.

When it comes to the projective methods, however, we find that they have one and all been created by scientists who were either psychoanalysts themselves, or psychoanalyzed, or working in close collaboration with psychoanalysts. The first projective technique used for diagnosis was C. G. Jung's word association test, which appears inadequate to our present day sophisticated point of view. Then came Rorschach, the Löwenfeld "World Test" (derived from the findings of Hug-Helmut, Anna Freud and Melanie Klein), the T.A.T., and in recent years the daily increasing lists of projective tests.

Of the batteries of tests I need not speak; we have two distinguished representatives of this method amongst us, David Shakow and David Rapaport.

All these methods have originated either from psychoanalysis, or have been profoundly influenced by psychoanalytic thinking. It is not too much to state that without the psychoanalytic approach they probably could not have been created.

Nevertheless you might well ask me for a more specific explanation how the training in psychoanalysis or rather in psychoanalytic theory can benefit research in clinical psychology. If you will permit me, I will illustrate this application of the psychoanalytic system to research problems by giving you a brief outline of the structure of my own research in infant psychology which is the one with which I am obviously most familiar.

This research is conducted within a very modest framework. The research personnel consists of:

1. Research Director, a psychoanalyst
2. Research Associate, a Ph.D. with psychoanalytic training
3. Research Assistant, Ph.D.
4. Research Assistant with training in academic psychology
5. Library Researcher, a Ph.D.
6. Technical Assistant for card indexing and film filing.

The investigations combine *intensive* study of single cases with an intensive observation of their environment and the relations existing between the single cases and the environment. On the other hand these observations are confronted with *extensive* quantitative group studies, conducted with an accent on the dynamic interplay within the groups. The environmental observations are in both cases conducted with a view of getting comparisons between different groups, different from the viewpoint of culture or subculture—different from the point of view of economic conditions and different from the point of view of race.

The viewpoints governing the investigations are the following:

(a) The infant is one factor within a field of forces.
(b) The field of forces is a result of interindividual relations.
(c) In this field of forces the infant's behavior and its manifestations serve as an indicator of shifts in the interindividual relations.

(d) The shifts in the interindividual relations make it possible to investigate the origin of the various forces becoming effective.

(e) Modifications in the field of forces make it possible to evaluate the relative magnitude of the energies involved.

(f) The introduction of modifications in the field of forces enables us to verify above assumptions.

These principles introduce into our experimental psychological approach the dynamic viewpoints of psychoanalytic thinking.

The other counter-part, the genetic approach, is introduced by:

(a) A careful case history of the individual child, which is followed, preferably from birth, through an appreciable length of time, ranging from one to several years.

(b) The successive administration of tests to each individual child provides a series of cross sections which, since they are repeated at regular intervals, result in a longitudinal view of the child's developmental history.

(c) On every occasion when observations are made the environment of the child is interviewed, thus supplementing the child's personal history with a history of the environment.

This study, now in progress for a number of years, was conducted primarily as "pure" research for the purpose of the verification or the falsification of psychoanalytic and experimental psychological theories. The study has yielded a number of such results. Over and beyond this it has yielded an increasing body of findings with both diagnostic and prognostic significance in the field of infant psychology and psychopathology. These findings have on one hand acquainted us with certain criteria of normalcy which we consider of paramount importance as a foundation for future research. They have on the other hand made possible not only diagnosis and prognosis, but also therapeutic recommendations which take the shape of modifications in the structure of the field of forces.

This result is in accordance with the results of "pure" research by many others, such as Rosenzweig's research into the theory of frustration which resulted in his suggestion of therapeutic immunization, of Mowrer's research into the theory of learning, resulting in recommendations for the treatment of enuresis, etc. All these researches are characterized by their being inspired by a thorough familiarity with psychoanalytic theory.

My own experience with the group with which I am at present working has led me to believe that such research activity is of unusual value in the training of persons otherwise not familiar with psychoanalysis and the dynamic approach. I find that my assistants who started with an academic training and who were completely innocent of any psychoanalytic knowledge have rapidly become familiar in the course of this work with dynamic thinking and a dynamic

approach to psychological problems. The dynamic approach has become second nature with them and they apply it automatically whenever confronted with psychological problems in completely different fields.

This experience encourages me to contribute a practical suggestion to the present discussion. Institutes have been suggested in which both psychiatrists and academic psychologists are to be trained simultaneously through work on clinical material. I would suggest that in such Institutes a "Research Training Center for Psychoanalytic Psychology" should be established which would also train simultaneously psychiatrists and clinical psychologists. The purpose of such a training in research would be to study groups as well as single cases and to study the single cases in reference to groups, subcultures and cultures. Thus the research would combine the study of the inner environment with that of the outer environment, and would confront the students with the interacting forces which become visible under such circumstances. Once the student has experienced the interplay of such forces he becomes able to combine systematic psychiatric knowledge from text-books with a living frame of reference.

Of course this research has to take place under the leadership of an expert instructor in psychoanalysis. It would be the task of the instructor to give the students adequate insight into the dynamics at work in the research performed. With the help of this insight they would gain an understanding of object relations in general and of transference in particular. From this automatically the role of the therapist on one hand, that of the diagnostician on the other becomes obvious.

The great advantage of this procedure is that, without personal analysis, the resistance of the student is circumvented. This training will not make the students into psychoanalysts; but it will teach them psychoanalytic thinking and it will require a very much smaller teaching staff than would be necessary for regular training in psychoanalysis.

Another advantage of such a research group with dynamic training is that it will make it possible to define the boundaries between the needs of illness and the needs imposed by education, by social and by vocational problems. It will define them by making these problems actual objects of the research undertaken, a really effective method of definition in contrast with the prevailing one which is either semantic or sentimental.

It appears from this example that in our opinion the question as to the role of training in psychoanalysis in the development of research in clinical psychology should be envisaged from two viewpoints:

1. A Research Training Center for Psychoanalytic Psychology can open up new fields of research and new vistas for the elaboration of more effective tools for the understanding of the total human personality, its structure, the forces which make it function and the ways of dealing with them under both normal and abnormal conditions.

2. A Research Training Center for Psychoanalytic Psychology can substitute to a certain extent for the traditional training in psychoanalysis without it being necessary for the student to go through a training analysis.

This double function of psychoanalytic training for clinical psychologists makes its inclusion desirable in the curriculum.

THE ROLE OF TRAINING IN PSYCHOANALYSIS FOR THE DEVELOPMENT OF THERAPEUTIC TECHNIQUES IN CLINICAL PSYCHOLOGY

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BEFORE proceeding to a breakdown of the multiply entangled problems of my topic, I feel the necessity for attempting a definition of terms: first, the expression "psychoanalytic training." This may mean any or all of the following: attendance of seminars on psychoanalytic literature, personal analysis, or conducting a psychoanalysis under supervision. Secondly, the term "therapeutic techniques": this is a far broader category and may include anything from an attempt to help a child learn to read to the treatment of a severe character disorder. Finally, "clinical psychology": this is an as yet ill-defined professional discipline whose areas of function and whose training needs we have come together to discuss. It must be amply clear that a brief presentation of the relationships of these three extremely broad categories can, at best, only attempt to delineate the *problems* a little more specifically.

The first question which presents itself is whether there is an essential difference for the psychiatrist and the psychologist in the role of psychoanalytic training for the development of therapeutic techniques. At first blush, it would seem that there is no difference and that the significant question is: "What is the role of training in psychoanalysis in developing an able psychotherapist?" However, we must decide at this point whether to discuss the ideal training program for the psychotherapist of the future and the role which psychoanalysis will occupy in it, or the immediate situation of the clinical psychologist and the place of psychoanalytic training in the existing scheme.

Although it is extremely tempting to flee from the current scene and its web of practical difficulties and to develop a blue-print for the radical revamping of the curricula of both the clinical psychologist and the psychiatrist, the critical urgency of the immediate issues dictate a temporary postponement of the discussion of radical revisions of these existing curricula. Some of the

previous speakers have offered provocative suggestions regarding the possible modifications of the education of psychologists and psychiatrists and have thus opened the way for future discussions along this line.

It seems that at this point a brief review of the present status of the clinical psychologist as therapist is in order. The issue is no longer whether he should start to do therapy; he has been doing therapy for a long time, with added impetus provided by the war. The issue is rather to find out precisely what he is doing, how he has been trained to do it, and what additional training he needs. Only on the basis of detailed and specific information of this sort will we be able to discuss concretely the role of *psychoanalysis* in training for therapy. This injunction for fact-finding is easier said than done. The officers of the Division of Clinical and Abnormal Psychology of the American Psychological Association have begun a systematic inquiry.

In the absence of a documented statement of current status, we must for the time being rely on our personal impressions. It is my impression that at present, persons with widely divergent backgrounds and interests are doing a great variety of things besides diagnostic testing all called "psychotherapy", and that the sole claim to homogeneity which this group of persons has is that all call themselves "clinical" or sometimes "consulting" psychologists. For the most part there is absolutely no systematization in these activities. Psychologists who do therapy in various social agencies such as child guidance clinics, veterans' installations, etc., as well as in private practice are largely self-taught, and in the best instances highly intuitive people who have shown themselves to have a "flair" for therapy, and have then proceeded with or without supervision to treat patients—relying on reading and day-to-day experience for their training. Many are excellent therapists, with keen sensitivity to the nuances of interpersonal relationships; others are irresponsible opportunists.

In addition to this largest heterogeneous group of psychologist-therapists, there are two other groups whose training is more systematic and uniform. The larger of the two issues from the training program conducted by Carl Rogers, earlier at Ohio State University and now at the University of Chicago; the smaller is composed of psychologists who have received analytic training as research associates of various psychoanalytic societies. (This group may or may not include those lay analysts trained abroad before 1938.)

In recent years, many clinical psychologists interested in therapy, faced with the closed door of psychiatry and the double-bolted door of psychoanalysis, have taken advantage of the opportunities for therapy and research in therapy offered by Doctor Rogers. The result has been a startlingly rapid growth of "nondirective" therapy among psychologists, a movement which is characterized by an almost complete divorcement from psychiatric (and certainly from psychoanalytic) circles even in the closest geographic proximity, e.g., at Chicago —a movement which is also characterized by extremely brief periods of training and by a rejection of some of the best-established principles of psychotherapy and psychodynamic theory.

The handful of psychoanalytically trained psychologists (there are probably no more than 30 in the country) have also been especially interested in developing research in psychotherapy but have not been encouraged to train other psychologists to do therapy nor to conduct research in therapeutic techniques. This group has, on the whole, maintained more avenues of communication with psychiatrists than have the "nondirective" therapists.

If this general impression is even roughly correct, it is immediately evident that our first task is to establish standards of training and conditions of practice for the psychotherapist before we can proceed in any but the most general way to the extremely important but highly specific problem of the role of psychoanalytic training in the development of the therapeutic techniques of the clinical psychologist. The essential aim in setting up such standards would be to preclude the possibility of establishing the *principle* of psychologists doing therapy without at the same time insisting that they receive training adequate to the job. At the same time, the statement by the joint committee of clinical psychologists and psychiatrists representing the American Psychological Association and the American Psychiatric Association respectively makes it clear that similar standards must be set up for psychiatrists. (*American Psychologist, Vol.* 1, *No.* 10, *Nov.* 1946, *p.* 521.) This committee has said, "There is no intention on the part of either profession to assume duties for which it is not well prepared by training"[1], and moreover that all types of psychotherapy require "the highest degree of competence and preparation on the part of either clinical psychologists or psychiatrists, and are best handled with a recognition of the interdependence of the medical, psychological, and social aspects."[1]

With regard to the specific question of the role of psychoanalysis in the training for psychotherapy, there can be little doubt but that an understanding of the workings of the unconscious and of psychodynamics generally is prerequisite in the training of a therapist who is to conduct psychotherapy which is not blindly empirical. However, one must recall that "psychoanalytic training" may mean many things and that we know very little as yet about what amount or kind of psychoanalytic training is necessary in order to carry out psychoanalytically oriented therapy successfully. We are in a highly strategic position to gather data on this problem if we observe carefully the development of young psychiatrists who are at present being trained within the general framework of psychoanalytic psychiatry. Thus far, the only point on which there is unanimous agreement is that one needs a *complete* psychoanalytic training in order to conduct psychoanalysis. Far more problematic, however, is the nature and extent of training in psychoanalysis which is required in order to conduct varieties of suppressive and expressive psychotherapy which are grounded in a solid psychodynamic understanding but which are not "psychoanalysis" in the strict sense.

In Topeka, we have had a chance to watch the kinds of pitfalls which present themselves to psychiatrists in training who receive didactic lectures on the psychoanalytic theory of personality development and on psychoanalytic psychopathology, both essential material for acquiring a psychoanalytic orientation

We have seen that by far the most common impulse for students in this situation who have not themselves been analyzed is to tend toward a kind of academic "wild analysis." Naturally, their supervisors are well aware of this tendency and often need to bend over backwards to emphasize the immediately available surface aspects of the therapeutic relationship. We can learn a great deal from these experiences which will be directly applicable to the problem of giving clinical psychologists analytic training. We may find that this overzealous and sometimes premature search for "deep" unconscious content can be avoided by an extremely careful sequence of courses and a more complete integration of clinical work with didactic teaching. Clinical psychologists will certainly be the beneficiaries of lessons learned in the training of psychiatrists who do not intend to become psychoanalysts.

On the strictly practical side: the problem of the acute shortage of teachers has often been raised in connection with the question of training psychologists in any form of psychotherapy and particularly in psychoanalysis. While this is certainly no trifling difficulty we cannot feel that it is insuperable. We have seen that certain basic material may be learned jointly; kinds of training which require individual sessions might be worked out on a quota basis. It would not be necessary to use the time of a "training analyst" for this purpose inasmuch as there are competent lay analysts who could carry out such training. Naturally, no such program of psychoanalytic training for psychologists can be contemplated without at the same time setting up safeguards against the practice of psychoanalysis without the collaboration of a medically trained psychiatrist—and as a matter of fact, in the selection of candidates for such training the emphasis might be on potential researchers in psychotherapeutic techniques, rather than on therapists as such. The problems are numerous and complex, but admit of solution.

To summarize: at present the clinical psychologist doing therapy is usually a person who has not undergone systematic or standardized training as a psychotherapist but who has "picked it up" as he went along. There are two exceptions to this: those few individuals who have received psychoanalytic training as research associates and have maintained working relationships for the most part with psychiatrists; and the rapidly increasing group of psychologists trained as "nondirective" therapists who work independently of psychiatrists.

In order to safeguard standards of training and conditions of practice for psychologist-therapists, it is suggested that: (1) a systematic assessment of the actual situation be made; (2) that such standards be established for psychotherapy in general; (3) that plans be made to strengthen the working relationships of psychiatrists and psychologists to preclude the development of a "psychologist's psychotherapy" divorced from psychiatric and psychoanalytic practice, e.g., the "nondirective" movement; (4) that quotas be established for the psychoanalytic training of carefully selected clinical psychologists with the hope of encouraging research; and (5) that competent lay analysts be used for this purpose while the training-personnel shortage is so acute.

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PRIMARY FACILITIES IN PSYCHOANALYTIC PSYCHIATRY

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I SHALL introduce my remarks autobiographically following the example of two or three speakers yesterday. This, I think, will help to clarify my own implicit premises in regard to the training of laymen for therapeutic psychoanalysis. Indeed, the whole development of analytic policy in the matter has to be understood in an historical perspective of the evolution of changing conditions.

Many years ago, I had no feeling of a difference in the essential qualifications for analysis which could be ascribed to medical or nonmedical preparations. My views began to change in 1932; in that year I heard the first convincing argument against the training of laymen, or at any rate against their training at that time. This was a remark of the Chairman of the Educational Committee of the New York Institute: he called to my attention that, no matter what your theoretical ideas about lay analysis might be, it was a fact that a very small fraction of the laymen who applied for training had achieved a thoroughly professional background in their own fields.

I then came to understand gradually that the professional situation in America was very different from that in Vienna. Here there was not the rigid barrier between the analytic group and the medical profession which existed in Vienna at that time. It is an historical fact that in Vienna several of the most able early students of Freud were found originally among laymen rather than among physicians and this was not so in America. Moreover, in America there was a situation which still exists, though to a less degree than in 1932 namely, that of a psychoanalytic movement violently threatened by a trend to

dilletantism. Many people who were poorly trained in their own profession and were professionally immature were beginning to practice analysis. They were acquiring it the easy way, disdaining medical or other thorough preparation, they merely got analyzed by this or that person and set up their offices. The woods were swarming with them, and I think one of the main reasons why Americans adopted a policy of excluding laymen from training was for protection from that professional menace rather than the theoretical objections to laymen.

Another factor which entered into determining this policy, and which was certainly very important in my own attitude, was actual experience with analysts without psychiatric or medical training in their therapeutic relationships with patients. Their perspective, rather than their factual knowledge, was different. They lacked what I could best designate as a "clinical orientation." There was a tendency to see clinical material in terms of analytic theory or any other logical structure rather than in terms of individual experience. They differed from the "seasoned intern" Dr. Kubie referred to, who is rapidly developing that aspect of the mind which depends on judgment and experience rather than on a text-book orientation. All these factors combined to induce me to become a member of the preponderant group in the American Psychoanalytic Association who did not favor, and do not favor today, the training of laymen of any professsional category for psychoanalytic therapy. I might mention one other factor in the development of this policy. New York was the largest psychoanalytic institute and assumed leadership in the development of both teaching and conducting a clinic. This created a legal problem, for New York could not get its license for an institute from the Board of Regents if they included non-physicians in their clinic.

These are some of the historical factors contributing to the pretty general concurrence of analysts in the "Minimal Standards" set up and adopted officially by the American Psychoanalytic Association and its constituent institutes in 1938. These were printed, are in existence today, and copies may be obtained by writing to the Secretary of the American Psychoanalytic Association, Dr. Robert Knight, at The Menninger Clinic, Topeka, Kansas. They included a formally adopted resolution against the training of laymen for therapy. At the time of their adoption, those laymen who were already accredited analysts were recognized as members of the Association and were qualified to continue the practice they had already established.

At the same time the principle was established that Class B candidates might be trained for the non-therapeutic application of analysis; these candidates were highly qualified people in nonmedical professions who could apply analysis to their special fields of research. Thus training of Class B candidates for this purpose has always been welcomed by all institutes and there has never been opposition to it. It has, however, produced difficult problems, arising chiefly from the fact that in principle what we want are highly qualified people applying analysis to other professions, not people using this privilege as an expedient for getting into therapeutic psychoanalysis through this back door.

At a meeting of the Board of Professional Standards of the American Psychoanalytic Association in December 1946, the policy in regard to the new problems of clinical psychology was discussed intensively. There was general acceptance of certain premises: first, the profession of clinical psychology exists, and a beginning has been made in some places to provide training in therapy; secondly, the number of these students, their increasing emphasis on therapeutic objectives, the development of opportunities for training, and the movement to provide official certification for therapeutic activities present many new problems; thirdly, these problems, very big and complex, will eventually be worked out to the advantage of everybody, including psychiatrists, psychologists, and patients, but this will take years of evolution; fourthly, psychoanalytic institutes are now swamped and cannot provide adequate facilities for the training of doctors, particularly the veteran doctors who are applying in such huge numbers.

After thorough discussion of these facts in the situation, the following resolution was passed, with a single dissenting vote:

"Whereas, it is the opinion of the American Psychoanalytic Association that the practice of psychotherapy is a medical function, therefore, be it resolved: That paragraph 1 of the 'Resolution Against the Future Training of Laymen for the Therapeutic Use of Psychoanalysis', as adopted by each constituent society of the American Psychoanalytic Association between January and June, 1938, and finally adopted by this Association as a whole at its meeting in Chicago in June 1938, and published by this Association, be modified to read as follows:

(1) All psychoanalytic institutes which are now recognized by the American Psychoanalytic Association shall henceforth not admit to training anyone engaged in or intending to engage in the individual practice of psychotherapy who is not a physician.

(2) Be it further resolved: That lay candidates for training in non-medical professions shall pledge themselves in writing that they are not engaged in practicing psychotherapy, and will not engage in practicing psychotherapy, except under the direction of psychiatrists in an organized clinic or hospital.

(3) Be it finally resolved: That in all other respects the former resolution against the training of laymen be reaffirmed."

This resolution has in just the past week been submitted to vote by the members of the American Psychoanalytic Association.

So much for the statement of the facts of the American Psychoanalytic Association's regulations on lay therapy—regulations not necessarily absolute for all time. The other topic that is implied by the title of this paper is one which I prefer to call "psychiatry" rather than "psychoanalytic psychiatry." I do so because "psychoanalytic psychiatry" seems to me an anachronism in that all psychiatry today in centers where there is progressive teaching,

progressive practice, and progressive leadership, is psychoanalytic psychiatry in the sense of having absorbed and applied principles that are basically psychoanalytic. Furthermore, "psychoanalytic psychiatry" as used by some people has implications with which I basically disagree. For instance, I disagree with the presumption that only psychoanalytically trained people can effectively practice dynamic psychiatry, and that only psychoanalytically trained people can understand the basic principles of analysis and put them to excellent therapeutic use. As a matter of fact, I know individual physicians, some of them on my staff, who practice as good if not better therapy than the analysts do because they do not get in too deep in spite of themselves. In the leading medical centers psychiatry has attained a development where the cleavage between those who practice psychoanalysis and those who do something else is rapidly becoming nonexistent. There are still many psychiatrists who are opposed to dynamic psychiatry, but there are many who have assimilated it and these in constantly increasing numbers are representative of what I mean by modern psychiatry.

Psychoanalysis today should be considered a basic science in psychiatry and is rapidly becoming a basic science in medicine—and I use the phrase "basic science" with very special and important implications. The analogy that is very clear in my mind is that of pathology after William Henry Welch introduced it in America about 1870. He had to fight against people who did not find these innovations necessary, did not recognize their importance for some years, yet eventually it became for two generations the basic science of medicine. Pathology interpreted the symptoms and the treatment of diseases in terms of what their pathological pictures were, what changes had occurred in the tissues, and the clinician was not considered worth his salt as a scientist if he did not thoroughly understand the relation of tissue damage to clinical picture. Today psychoanalysis has a similar position. While the specialized skill for applying the psychoanalytic method to research and to therapy is still something requiring an intensive special training, the basic principles of psychoanalysis are very readily understood by the psychologically minded people of the modern psychiatry clinic. This is certainly true of fourth year medical students in recent years, though not those of ten or even five years ago. They understand these principles, they do not need to argue about them, when they are illustrated by clinical material. The more mature psychiatrist today takes for granted the existence of the unconscious, its fundamental role in adjustment, the clinical evidence of repression, the understanding of the genetic significance of behavior patterns and of object relationships in adult life. These basic derivatives of analytic research are not only accepted without argument, but are applied extensively by psychiatrists who have not specialized in psychoanalysis. At times our estimates are biased by the outworn overemphasis of resistances to analytic understanding. Today we should reappraise the idea that all resistances are rooted in the Oedipus complex. Probably there is also a cultural resistance in the sense of the human inertia in accepting something new. A definite cultural process has transpired. One can observe it in the response of medical students to good dynamic teaching. They do not need to argue the points we incessantly battled about with contemporaries for 30 or 40 years.

Through the subterranean passages of cultural development these ideas have been transmitted to the minds of the youth of today and in consequence they do not establish the rigid resistances to analytic principles with which we have been long familiar.

It is for these reasons that I talk about "psychiatry" rather than implying that there is a special "analytic psychiatry." All good psychiatry today has psychoanalytic principles and clinical demonstrations as its foundation, and I am sure it is rapidly becoming one of the basic sciences in medicine.

I have to follow Dr. Brenman's example in speaking of impressions of what are the training facilities in psychoanalytic psychiatry, the training in the psychiatry in which we are interested. I feel they are essentially represented by Dr. Kubie's statistics yesterday from the 20 medical schools with up-to-date departments of psychiatry in the country. Dr. Kubie remarked that this is a very rough approximation, and the number is probably fewer. The other schools are, of course, the potential foci of modern psychiatric teaching, and will probably very rapidly become psychiatric centers, too. The training facilities of those with progressive departments are best known to me through the discussion of the Committe on Medical Education of the Group for the Advancement in Psychiatry. One thing which characterizes all such places is the fact that psychoanalysts do play a prominent role, not in teaching psychoanalysis and not in converting proselytes to psychoanalysis—that day is past, thank goodness—but in their contribution to the psychiatric setup and in their part in its teaching activities. The training facilities, however, are not exclusively those of instruction. There are other improvements which we should promote as rapidly as possible. The most important point is that these training facilities in medical schools are outstandingly inadequate in the pre-clinical training. Indeed I do not think there is any medical school where the pre-clinical training which is provided is what we should reasonably expect in terms of modern psychiatry as a basic science. This special problem was much discussed at the recent meeting of The Medical Committee of The Group for Advancement in Psychiatry. It involves many practical problems, the finding of time within medical school curricula, and the consent of the gray-beards in the medical schools. Our Committee agreed that what used to be called and is called today pre-clinical teaching should pretty much go by the boards. There is a great deal of discussion in several medical schools of introducing clinical work earlier and teaching it conjointly with what used to be called pre-clinical work. Improvement in psychiatric teaching in the first and second years involves an adequate presentation of the nature of psychological data and personality development and can best be taught by the seminar method rather than the lecture method. The student should have by the end of his second year a pretty good idea of what are the basic principles which he is to use in clinical psychiatry and he should have a thorough grounding in the elements of interviewing. We feel that you cannot wait till the third or fourth year to introduce psychiatric interviewing, as we do now; you teach the medical student an interrogatory method of history taking and then, if you

are an up-to-date teaching institution, you unteach him and show him some of the principles of associative interviewing. Instruction in elementary interviewing could be begun early in the first year. The third thing which should be introduced as soon as possible is an introduction to clinical psychology. Medical students should know the principles of psychometric testing and diagnostic testing and also the basic principles of sociology and anthropology, and should learn them early in their medical education.

In summary then I should say:

(1) It has been for many years, and it continues to be, against the policy of The American Psychoanalytic Association and its constituent teaching institutes—and against the convictions of a very high percentage of its members —to provide analytic training for the practice of any method of psychotherapy by laymen, except under the supervision of psychiatrists in well-organized clinics and hospitals;

(2) The training of psychologists, as well as other lay professionals of higher caliber, in psychoanalysis for its applications to non-therapeutic aspects of other sciences is legitimate and highly favored;

(3) In progressive departments of psychiatry in a minority of American medical schools, good programs of clinical teaching of dynamic psychiatry in the third and fourth years are rapidly developing, while pre-clinical teaching in the first and second years is universally poor, if not worthless.

Morning Session

March 28, 1947

SUMMARY OF THE DISCUSSION

KUBIE: I have thought a good deal, last night and at various intervals during the morning, about the problems which have been high-lighted. I think that we can summarize them under various headings:

(1) We take off from an existing situation of great complexity. There is the tremendous human need, which has in fact become an aroused and articulate demand. We are cognizant of the total inadequacy of our resources for meeting that need. Not from medicine, not from psychiatric social work, not from clinical psychology are we equipped to meet this need today. We recognize also that unless we do the job ourselves charlatans will exploit this need. Where science fails to respond to human needs charlatans always flourish. Consequently this event of momentous importance in human culture (i.e., the fact that people have been aroused to the realization that they need help in their

emotional lives, and that emotional problems are part of the phenomena of human illness), this great cultural advance may lead to the worst kind of exploitation, if we fail to do our job.

(2) This brings me to the second general agreement that has come out of these discussions, namely, that somehow or other, some technique of control must be established for those who are going to attempt to meet this need. In any final sense the process of control is a function not of science, nor of any scientific discipline, but of the State. However, we also know, as previously pointed out, that in any scientific field if legal action is taken prematurely it tends to freeze the status quo into a rigid form and often places under unenlightened, bureaucratic restrictions something which should still be in a state of flux and experimentation. Therefore, it would be well if some clear definition of sound scientific policy, detailed yet flexible, and alternative sets of curricular requirements could be evolved by scientists before any precipitate and ill-considered legislative action occurs. In this connection the question has been asked several times: Should scientific certification precede licensing by the states, or should licensing come first? Certainly there is a difference between certification by a scientific group, and licensing by states: and although in medicine, historically, licensing preceded certification, certification has been instituted because of inadequacies in our system of medical licensure, that is because the licensing system does not recognize different special kinds, qualities and degrees of medical skill. Consequently the certification of the specialist has been added as an extra-legal supplement to legal licensing processes.

This matter may be something for us to consider at future meetings. However, even then it would remain our function to try to outline what constitutes sound scientific policy in this field. This might become the basis for some certification procedure which, in turn, could ultimately become a sound basis for legal restrictions by state controls, for the prevention of abuse and charlatanry.

(3) This brings us to the third issue, i.e., whether we participate in the entire process or whether we confine our efforts and attention to only one part of it. The scientist must serve not merely the immediate demand for therapy, but also the long-run need for research and for teaching. There was much discussion of the extent to which premature emphasis on therapy may endanger research. There is danger of a deflection of personnel out of research and into therapeutic activities because of greater financial rewards and the personal economic security in therapy. Equally important is the extent to which preoccupation with therapy may obscure one's vision, lessen objectivity, and make one a less critical scientist. To some extent, the bad effects of becoming too preoccupied with therapy are tied up with the issue of private practice, where the confusing influences are likely to be greatest. On the other hand, it has also been pointed out that experience in therapy is an important part of training for research. Whether it is an essential and necessary part is another question; there can be no question, however, but that there is an inter-relationship,

a cross-fertilization between the effort to alter human psychological processes and to understand them. An understanding of human beings has ultimately to be tested against the ability to change them, just as in all medicine our understanding of a disease process has ultimately to be tested against our ability to alter it. Therefore, there can be no hard and fast line between training for research and training for therapy. The two are closely inter-related; and this must be kept in mind in any rounded training program.

(4) This brings us to the next important point. If all of this is true, how can it be organized? How can it be set up? Is it to be set up under medical auspices? Is it to be set up under academic auspices? Can it be set up in conjunction with schools of psychiatric social work or under some kind of conjoint auspices? The interesting suggestion was made that perhaps what we need are independent schools of psychology, rather than departments of psychology in universities, or psychiatric departments in medical schools. Obviously there are dangers of splitting things apart where one wants to cement the disciplines together in order to infiltrate other disciplines; but nonetheless the idea of independent schools for the psychological disciplines, wherein one center conjoint or overlapping training for psychiatrists, clinical psychologists, psychiatric social workers, and psychoanalysts would be offered, is interesting and thought-provoking. Perhaps, with affiliations with universities, with cross-affiliation with medical schools, such schools of psychology might best meet the need of the situation.

(5) I will not go back over what we discussed yesterday, namely, the organization of the curriculum, and so on. That is covered in another part of our summary; but a question has come up with considerable emphasis, both this morning and yesterday evening, namely, *when to train.* Underlying that is a recognition of the fact that training in the psychological disciplines presents special problems and makes special demands, more particularly for a certain degree and kind of emotional maturity over and above the keenness of a student's intellectual machine. The problem of how to gauge emotional maturity as a prerequisite for training in the understanding of human personality is difficult; and is related to such questions as when it should come in the curriculum and if it is to be while in medical school, in which year it should start. Here we had the interesting suggestion that it should start with the first day the student is in medical school, that at the start the medical student has not been corrupted by the medical curriculum, that he has come with a spontaneous, naive, and eager emotional interest in human beings, and that he is susceptible to psychological influence. After he has been around medical school for a time he becomes psychologically immune and increasingly difficult to instruct. Also it was pointed out that there is a tendency in modern medical education toward early exposure to clinical experience. This has certain interesting implications. It means that the first year medical student, when he is in the same state of maturity and knowledge as any other recent college graduate, is immediately confronted with human beings and their problems. At that point, therefore, the graduate student in any department of psychology

and the young medical student are quite on a par as to knowledge and emotional maturity. They have not yet been made into different human beings by the medical curriculum; and if the one can be infected with a mature interest in human personality, then it ought to be equally possible with the other, provided it is done under proper auspices and in a proper atmosphere. There is the further implication that early contacts with human beings, who are suffering either emotionally or physically, can of themselves exercise a maturing influence on students and may be one of the most important first steps toward a new medical curriculum.

(6) This leads to a suggestion which was made to me by telephone this morning by Dr. Binger, who could not be here today. He asked me to present this for him as an extension of what he said yesterday; and it fits into the summary at this point. He pointed out that the certification of medical specialists is important. He reviewed how it had arisen as a reaction to the anomalous fact that a man who steps out of medical school and gets his license has a legal right to do brain surgery the next day. That is obviously wrong; and Dr. Binger's idea was that some day we would have restrictions so that a physician would not have a right to do psychotherapy unless he had, in addition to a medical degree, a doctorate in psychotherapy or in medical psychology; *but that this doctorate would also be earned in medical school.* Furthermore, it would be open to men who had been through a pruned medical curriculum as well as to men who had been through the complete medical curriculum. In other words, his motion was that there should be a new doctorate in psychotherapy or in medical psychology: and that those who held this doctorate would be in two groups: 1) those with an M.D., and 2) those without an M.D., but who had been through a partial medical curriculum in medical schools and teaching hospitals to give them those elements of the medical curriclum which are essential for psychotherapy. That really amplifies more concretely what we discussed yesterday.

(7) The next topic that comes up at this point, concerns the special role and the special problems of psychoanalysis in such a development. Here many difficult and special questions must be answered. First, can anyone be trained to an understanding of psychoanalysis without going through a personal analysis? This is an important theoretical and practical issue, because the bottleneck in training is the shortage of training analysts to give training analyses. Somewhat to my surprise and interest there was a rather large degree of agreement that it was possible to give a profound understanding of basic psychoanalytic theory and technique without subjecting everybody to a personal analysis. I am sure that many people will object to this; but here at least the agreement was general and included even the analytic group. Drs. Kris, Spitz, Rapaport and Brenman all took this position, although there was some question whether training for the understanding of psychoanalysis and training for the therapeutic application of psychoanalysis can be given in the same way. The question also came up whether one can learn about psychoanalysis in this general cultural sense and also as a specific therapy without having had the

actual experience of *doing therapy.* If one has to have the experience of doing therapy in order to understand analysis, then everyone who wants to understand analysis must be analyzed. Here again the issue comes up, what about research? Can you do research in analytic processes and in the analytic understanding of the personality without having had experience in therapy? These are questions which have been argued pro and con without reaching any final decision. Perhaps just to confront ourselves with the issues is in itself of some value at this point.

(8) The next question that was brought up, and one of far-reaching importance, was the influence of a well-developed program of training in clinical psychology on the status of psychology in general and on the atmosphere of medical education. Without going into that in detail it is important to place the matter on record for future consideration.

(9) Finally came the question with which we started, namely, what are we training for? Are we going to train everyone for the same all-inclusive functions in the field of clinical psychology? Are there differences in the percentage distribution of pure scientists and applied scientists in the various psychological disciplines, which in turn should lead us to develop a variety of different educational programs? Are there differences in the percentage of practitioners in relation to teachers, and to researchers? etc. . . It was pointed out that in psychiatric social work the preponderant emphasis has been on training for practice and teaching, with relatively little emphasis on training for research. In clinical psychology on the other hand, there has been too little training for practice, with an over-balanced emphasis on training for research. The recognition of these differences in emphasis high-lights some of the problems we have discussed.

APPENDIX

SUPPLEMENTARY COMMENTS CONTRIBUTED BY MEMBERS AFTER THE FIRST MEETING

FROM GEORGE E. GARDNER:

I WOULD like to expand my suggestion that the establishment of a School of Psychology within the university which would be independent of both the Medical School and the academic Psychological Departments, but nonetheless drawing upon both groups for their faculty, would in large part solve many of the difficulties which confront us in mapping out the future of Clinical Psychology and the role of Clinical Psychologists.

As I suggested in my brief discussion, there is a certain core of basic psychological knowledge that it is imperative to impart to a large number of

allied professions that are being trained simultaneously in any large medical center, namely,

1. Clinical psychologists
2. Social workers
3. Medical students
4. Candidates in schools of nursing
5. Theological students
6. Graduate psychiatrists in their fellowship training years, and
7. Teachers and educators.

The first year training in this School of Psychology would be aimed at the fundamental basic courses in human behaviour that all of these varied disciplines need as a groundwork for their future specialization. Some would be required to take the complete first year course, and this would be true, of course, with our Clinical Psychologists. The other groups would take but one or two of the basic courses as it was thought necessary for them. But in the second, third and fourth years of such a School, there could be specialization for the varied types of Clinical Psychology that are needed by the various institutions in our present day society. And I might say here that in our conference we have not stressed enough the tremendous amount of specialized variation that there is in this group called Clinical Psychologists, ranging from the therapist who spends all of his time in treatment, to specialized areas such as remedial work with reading difficulties, consultant work to courts, or Pupil Accounting Departments in public school systems. It seems, then, that our plans for specialization are more easily formulated than are our plans for the basic courses necessary for all of them. At any rate that would seem to me to be a starting point in the establishment of a profession of Clinical Psychology, and your expansion in the direction of medicine or in the direction of the academy could take place as was dictated by the needs of society as we went along year by year. By a School of Psychology, of course, I am not referring to theoretical concepts, but I am referring to a School fashioned and administered after the manner of the present day School of Education, School of Social Work, or School of Dentistry as we know them.

On the other hand, such concentration of the basic knowledge and grouping of the faculty members who impart such knowledge into one faculty and under one administration would in large part eliminate the enormous amount of useless duplication and reduplication of lectures, and seminars, and the conflicting and competing demands and requests for field work, field work supervision, and apprenticeships—all of which confront those of us who try to teach and train in these areas. As an example of this, it is not unusual for training psychiatrists at the present time to be called upon to give identical basic lectures in (a) a School of Social Work, (b) a School of Nursing, (c) to third year medical students, and (d) to first year graduate students in Clinical Psychology—all in the same semester in varying parts of the university town, and all this when the instructor himself knows full well that all of them could receive the same lecture in these basic initial stages of their training.

Finally, the establishment of such a School would tend (1) to solve many of the difficulties that arose from some of the suggested programs. (For example, such a School would soon be giving us the therapists that Dr. Kubie's plan calls for, though probably never in such great numbers as to meet the social need); (2) would make the School of Psychology independent of medical school direction, but on the other hand it would allow for the closest type of cooperation between the faculty of Clinical Psychology and the faculty of Psychiatry; (3) would divorce in the main Clinical Psychology from the rather sterile direction of the academicians and allegedly "brass instrument" psychologists; (4) would comply in part with Dr. Brosin's request that diagnosis and research could well be the main function of the Clinical Psychologists or at least a goodly proportion of their numbers; (5) would allow for preparation for these men and women to *do* therapy if desired and thus comply with Dr. Shakow's feeling that Clinical Psychologists should be trained to do therapy as an aid to the structuralization of their research programs and that their research programs in turn should be aimed at future therapeutic devices as well as the formulation of diagnostic tools; (6) and, finally, it would allow for the application and expansion of Evaluation Methods that were thought by so many to be so desirable and needful.

In conclusion, it seems to me that the establishment of a School of Psychology, at least a pilot school (endowed perhaps), is practical and that it could be set up without any tremendous wrench of the medical or university administration in any of our large medical centers.

FROM WILLIAM LINE:

In the hope that I may be permitted to continue to share the deliberations, I am writing, in summary, my understanding of the problem.

A Clinical Psychologist, defined at least implicitly, is one who has accepted the postulates of Dynamic Psychology at least to the degree that he is willing to work with them.

Clinical Psychology by and large has other definitions, none of which is as systematically clear as the above. The general, ill-defined, traditional meaning has references to working with "sick" people—with little clarity as to what "psychological" work is (beyond psychometrics).

The specific definition of the conference draws attention to the fact that the postulates of psychodynamics were, and are, grounded in a therapeutic setting. It is therefore inevitable that a psychologist working with these postulates must be involved in therapy—not necessarily *as* a therapist, but in understanding some basic therapeutic principles.

I agree, therefore, that the plea is most sound—that the Clinical Psychologist thus defined must be trained in the atmosphere, ethos, moralities, etc. of the therapeutic situation. Such a training outline appealed to me very much.

But the complement of psychological training (by Departments of Psychology) is another matter.

Psychodynamics can be taught only by a psychiatrist well-experienced in psychoanalysis. The idea of lay people teaching psychodynamics is controversial.

There are *no* qualified teachers of psychodynamics in any university Department of Psychology on this continent to my knowledge. There are a few fairly competent psychologists who try to teach psychodynamics in universities. But I think this is likely to do no good. The incompetent text-book people do harm.

In Canada, there is no competent psychiatrist for this purpose. In the United States, there are a few—not as many as is generally supposed; certainly not nearly enough.

There are teachers associated with informal settings such as Tavistock and Topeka. But I'm concerned about the "formal" university setting.

Medicine is, in general, somewhat critical (fearful) of psychodynamics, the central rationalization being that the research underpinning is inadequate. This is a fact to be reckoned with.

The setting up of a special training division for this clinical psychologist need, may alienate both medicine and psychology (in the university sense).

I see the danger of forcing university psychology into the arms of traditional or reactionary university medicine—in much the same way that some of our progressive child-study psychologists are being forced back into the arms of the old-line pediatrician unless we handle this problem—not through Tavistock or Topeka—or even through special institutes or new courses of professional training—but through the universities and the "orthodox" professional associations.

Therefore, at the moment, my points are these:—

(1) Invite University Psychology to cooperate on the basis—not of training "therapists", (great as is the need)—but of research. (Let institutes train the workers in the field).

(2) Invite University Medicine to permit psychodynamic teaching (in every conceivable phase)—not as a gospel, but as a "point of view."

(3) Make clear to medicine that the partnership of psychology is established on a research basis.

(4) Make clear to psychology that *its* job is to examine—systematically and experimentally—the basic postulates of psychodynamic theory.

(5) Transfer "psychological teaching to medical students" from psychology departments, to psychodynamic psychiatrists—in cooperation with psychological research staff as above designated.

FROM ROBERT W. WHITE:

I am not sure that I phrased my suggestion clearly at the conference. Let me try to restate it now. I agree that clinical psychologists are going to do therapy, out of the force of circumstances as they exist today, and that the most urgent question is how to train them and how to give them the proper experience, so that this therapy will be competently done. It was necessary, I am sure, for us to discuss "the question of lay therapy" and to line up the difficulties surrounding it, bringing out into the open the misgivings of psychiatrists lest such therapy be incompetent, and bringing out equally (it seemed to me) the misgivings of psychologists lest the demands for therapy lure the profession away from its tremendously important research task. To me, at least, it was one of the clearest findings of the conference that all of us regretted the existing situation and the tremendous pull it is going to exert toward therapy. But the situation exists. (I was most happy at the way we kept bringing this fact back into the debate whenever "the question of lay therapy" was discussed as if the year were 1937 instead of 1947). My problem is how to go at the task of training clinical psychologists in a fairly short time so that they will be able to assist competently in meeting the current need without, however, striving to become the equivalent of a psychiatrist and without reaching the level of competence and experience at which they might be expected to function without psychiatric supervision. If the social worker is able to bear part of the therapeutic task on the strength of two years of professional training, it should be possible for the clinical psychologist similarly to bear part of the load by virtue of four years. I would like to have this question considered quite concretely. Perhaps the therapeutic activities of clinical psychologists should be limited to nondirective counseling which is readily teachable. Perhaps certain of the therapeutic specialties, like play-therapy with children, and group psychotherapy with adults, could be allocated to the psychologist. I am not sure that any of these suggestions are right, but it is along such lines that I would like to see further concrete discussion. It may be that the four year program is too short to accomplish what we would like to teach, and I think consideration should be given to the possibility of a fifth year.

FROM ERNST KRIS:

I am much interested in a project for a "School of Clinical Psychology" and might possibly be able to make a few useful suggestions provided that what we envisage is not a basic or undergraduate training but on a postgraduate level.

Under this condition I should think that three areas should be considered:

(1) Clinical Training:

Here stress should be laid on bringing criteria as close to psychoanalytic concepts as possible. Much work has been done in this

direction but a good deal more needs doing. Training here will at every point touch research. This part of the work would probably presuppose access to clinical material which a clinic might greatly facilitate.

(2) Theoretical Training:

In order to make tests more useful to psychoanalytic clinicians the psychologists must be trained in basic concepts. I think that this part is no less complex than the clinical training itself. Were the project in a more advanced stage I would try to make concrete suggestions. At the Graduate Faculty I have taught a good many clinical psychologists and they are receptive but many need thorough re-education.

(3) Clinical Training and Theoretical Work:

Both could be combined with research. The prejudice amongst psychoanalysts against organized research is still fairly great. Here is a point where this prejudice could be discussed in detail.

Needless to say that apart from these three areas there are many concrete problems one might wish to discuss; for example, problems of selection. Clinical psychologists trained in various institutions are of very different standing indeed and only a careful selection can make this work worth while.